FISCAL YEAR 1988 BUDGET RECONCILIATION ISSUES RELATING TO THE REIMBURSEMENT OF HOSPITAL CAPITAL EXPENDITURES UNDER THE MEDICARE PROGRAM

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDREDTH CONGRESS

FIRST SESSION

MAY 4, 1987

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FISCAL YEAR 1988 BUDGET RECONCILIATION ISSUES RELATING TO THE REIMBURSEMENT OF HOSPITAL CAPITAL EXPENDITURES UNDER THE MEDICARE PROGRAM

MONDAY, MAY 4, 1987

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The subcommittee met, pursuant to notice, at 1:10 p.m., in room B-318, Rayburn House Office Building, Hon. Fortney H. (Pete) Stark (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

FOR IMMEDIATE RELEASE
WEDNESDAY, APRIL 29, 1987

PRESS RELEASE #11
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE FORTNEY H. (PETE) STARK (D., CALIF.), CHAIRMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES A HEARING ON FISCAL YEAR 1988 BUDGET RECONCILIATION ISSUES RELATING TO THE REIMBURSEMENT OF HOSPITAL CAPITAL EXPENDITURES UNDER THE MEDICARE PROGRAM
TO BE HELD ON MONDAY, MAY 4, 1987

The Honorable Fortney H. (Pete) Stark (D. Calif.), Chairman, Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives annnounced today that the Subcommittee will conduct a hearing on Fiscal Year 1988 budget reconciliation issues relating to the reimbursement of hospital capital expenditures under the Medicare program. The hearing will be held on Monday, May 4, 1987, beginning at 1:00 p.m., in room B-318 Rayburn House Office Building.

In announcing the hearing, Chairman Stark said, "Capital expenditures define the size, shape, and technological level of our hospital system. Designing an equitable system of reimbursement for these expenses is a critical issue facing the Congress this year."

The Subcommittee hearing will provide a forum for presentation of the Administration's proposal on capital reimbursement. Hospital representatives and other witnesses will have an opportunity to comment on the Administration's proposal and to present alternative capital reimbursement proposals.

Oral testimony will be heard from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

BACKGROUND

The prospective payment system (PPS) was adopted by Congress in 1983 as the method of hospital payment for Medicare. Payment for certain capital-related expenditures -- depreciation, rent, and interest -- was not included in PPS due to uncertainty about the impact of including capital reimbursement in the system. These costs were to continue to be reimbursed on a retrospective, cost-based system until October 1, 1986. P.L. 99-509, the Omnibus Budget Reconciliation Act of 1986, further delayed inclusion of capital in Diagnosis Related Groups (DRGs) until October 1, 1987.

Congress directed the Secretary of Health and Human Services to study and report to Congress (by October 20, 1984) on methods and proposals for including capital-related costs in PPS. The report was submitted in March 1986.

If Congress does not enact legislation to include capital-related costs under PPS by September 30, 1987, Medicare payments for capital costs will be prohibited after that date unless a State has recommended approval of a specific capital expenditure under section 1122 of the Social Security Act.

The Administration and the Prospective Payment Assessment Commission (ProPAC) have both proposed inclusion of capital payments in DRGs beginning in Fiscal Year 1988. Prospective payment for fixed capital would be phased in over ten years under both proposals while payment for moveable equipment would be phased in over two years under the Administration's proposal and three years under the ProPAC proposal.

WRITTEN STATEMENT IN LIEU OF PERSONAL APPEARANCE

For those who wish to file a written statement for the printed record of the hearing, six (6) copies are required and must be submitted by the close of business on Friday, May 29, 1987, to Joseph K. Dowley, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

SEE ENCLOSED FORMATTING REQUIREMENTS

*****

Chairman STARK. The Subcommittee on Health will continue its consideration today of the hospital payment issues raised in the 1988 budget reconciliation legislation. This hearing will discuss the question of reimbursing hospitals for their capital-related expenses.

The prospective payment system was adopted in 1983 as a method of hospital payment for Medicare. Payment for capital-related expenditures was not included in the PPS due to uncertainty about the impact of including reimbursement in this system.

This issue, of course, was debated at length last year. I had hoped, given last year's extensive discussions, that we would be discussing a consensus proposal by now.

The time has come to move to the fully prospective payment system that the law envisioned. The present mixed system of prospective payment for operating costs and retrospective payment for capital costs makes little sense to the Chair.

I would also note that the inclusion of a transition period for bringing capital into prospective payment allows ample opportunity to monitor the implementation of the system and identify any potential problems. It is important that we think now how best to assure that this monitoring function be carried out.

The administration and ProPAC have both recommended including payments for capital in the prospective payment system. I agree that the time has come to move forward to create a fully prospective payment system. I say that, understanding that there will be a lot of adjusting needed, but I am still firm in the belief that adjusting one system is a lot simpler than adjusting two systems and then trying to put them together into an effective third system.

I want to thank our witnesses for being with us today, and I look forward to their testimony. I would like to ask unanimous consent at this time that all prepared statements be included in the record in their entirety, including the prose of my extended opening remarks.

[The statement of Mr. Stark follows:]

OPENING STATEMENT THE HONORABLE FORTNEY H. (PETE) STARK

Today, the Subcommittee continues its consideration of hospital payment issues raised by the 1988 budget reconciliation legislation. We will focus, in this hearing, on the question of reimbursing hospitals for their capital-related expenses.

The prospective payment system was adopted by Congress in 1983 as the method of hospital payment for Medicare. Payment for capital-related expenditures was not included in PPS due to uncertainty about the impact of including capital reimbursement in the system.

Congress directed the Secretary of Health and Human Services to study and report to the Congress on a proposal to include capital in the prospective system. The report was submitted in March 1986. Last year, Congress delayed inclusion of capital in the prospective payment system until October 1, 1987.

This issue was, of course, debated at length last year. I had hoped, given last year's extensive discussion, that we would be discussing a consensus proposal by now.

The time has come to create a fully prospective payment system. The present mixed system of prospective payment for operating costs and retrospective payment for capital costs makes little sense.

Retrospective cost-based reimbursement creates distortions which demand correction.

The pass-through assures that hospital managers will be insensitive to interest rates or alternative methods of financing. It may lead hospitals to invest in facilities that are not needed by the population served, thereby creating additional excess ca-

pacity. The pass-through creates inappropriate incentives to substitute capital for labor or other operating costs.

Many have argued that including capital in the prospective payment system will unduly disadvantage some hospitals. In my view, this is a legitimate concern to which the Subcommittee should respond. I hope that our witnesses today will particularly address what alternatives exist for responding to the small group of hospitals which may experience financial hardship as a result of a new policy.

I would also note that the inclusion of a transition period for bringing capital into the prospective payment system allows ample opportunity for monitoring the implementation of the new system to identify potential problems. If we determine that quality of care and access to care are in jeopardy, remedies can be developed. It is also important that we think through how best to assure that this monitoring function is carried out.

Both the Administration and ProPAC have recommended including payments for capital in the prospective payment system. I agree with them that the time has come to move forward to create a fully prospective payment system.

I would like to thank our witnesses for appearing before the Subcommittee today. I look forward to their testimony.

Chairman STARK. I recognize Mr. Gradison, our ranking member.

Mr. GRADISON. Mr. Chairman, I am glad that as we begin consideration of reconciliation and try to get a little bit ahead of the curb on this, that this is set down as one of the first hearings. It is a very important subject, and I look forward to the testimony.

Chairman STARK. We will hear first from the Health Care Financing Administration, Mr. Ross Anthony, the Associate Administrator for Policy. I would like to suggest to the other witnesses that we are, if we have enough staff help, going to run the clock today after the administration testifies, as is our tradition. It is based on the theory that we can read the prepared testimony a lot quicker silently than you can repeat it, and that we often can extend the value of your prepared testimony by asking questions and letting you summarize it or emphasize it in any manner you are comfortable.

So, I say that to future witnesses. We, too, will try to hold our questioning, be brief to accommodate those who have other things to do this afternoon.

Mr. Anthony, with the luxury of all the time you want, why don't you proceed in any manner you are comfortable.

STATEMENT OF C. ROSS ANTHONY, PH.D., ASSOCIATE ADMINISTRATOR FOR PROGRAM DEVELOPMENT, HEALTH CARE FINANCING ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. ANTHONY. Thank you, Mr. Chairman. It is, indeed, a pleasure to be here today to speak about phasing capital costs into the prospective payment system. I would like to present the administration's program and policy, and I will try to summarize my testimony in 6 or 7 minutes.

When the PPS was enacted in 1983, capital continued to be reimbursed on a reasonable cost basis. In compliance with the original statute, we published a notice of proposed rule making in 1986 proposing a prospective payment policy for capital. However, with the passage last July of the Urgent Supplemental Appropriations Act, the implementation of an all-inclusive hospital rate was postponed until October 1, 1987.

We are now proposing a change in Medicare payment policy for hospital capital which is very different from last year's proposal. It

is a product of extensive study as well as consultation with ProPAC and members of the industry. We believe the change we are proposing in Medicare payment policy for hospital capital is a useful next step for attaining the efficiency and quality goals of the prospective payment system. It is also a more rational and less interventionist role for government as a major payor of hospital services.

Historically, under cost-based reimbursement, hospitals were paid for their capital investments based on Medicare's proportionate share of inpatient services. Unlike the prospective payment system, Medicare's current approach to paying for capital costs is insensitive to volume and is dependent, rather, on merely the proportion of Medicare beneficiaries using hospital services.

For example, if a 300-bed hospital has one-half of its beds filled by Medicare patients and half of its beds filled by non-Medicare patients, Medicare will pay approximately 50 percent of the hospital's post-OBRA capital expenses. On the other hand, if the same 300-bed hospital has one-quarter of its beds filled by Medicare patients, and no beds filled by non-Medicare patients, Medicare will pay all of the hospital's post-OBRA capital expenses. Thus, in this example, while Medicare utilization for hospital services has declined, Medicare capital payments have increased.

In fact, between 1981 and 1986——

Chairman STARK. Excuse me. Are you saying that if you have a 300-bed hospital, and you are saying if it is running 75 percent vacancy.

Mr. ANTHONY. That is correct.

Chairman STARK. Let us call it a 100-bed hospital.

Mr. ANTHONY. That would be easier.

Chairman STARK. So it has got 25 full beds and it sits with 75 empty beds, Medicare picks up the capital based on a hundred beds, assuming it is a 100-bed building and they are getting reimbursed?

Mr. ANTHONY. If the proportion of patients in this case is 100 percent Medicare patients, then, in fact, we pick up 100 percent of costs. That is our share. The share is calculated on Medicare patients per total patients.

Chairman STARK. So if the facility buys a CT scanner and has one patient, who is a Medicare beneficiary, the Federal Government will pay for the whole CT scanner?

Mr. ANTHONY. Yes, we would pay for it as a Medicare capital cost.

Chairman STARK. I like that.

Mr. ANTHONY. Between 1981 and 1986, we see that hospital occupancy rates have declined by about 20 percent, and Medicare, on the other hand, has continued to reimburse hospitals based upon total occupied beds. In essence, Medicare's capital reimbursement system is subsidizing hospitals for empty beds—exactly the point that you were making.

Furthermore, the current cost-based system for Medicare's payment of capital costs gives hospitals very little incentive to purchase capital efficiently. In fact, the Medicare cost-based capital system, which, after OBRA, pays a hospital for almost its entire share of Medicare interest and depreciation expenses, gives hospi-

tals the incentive to increase their cash flow by investing in debt-financed capital. The increased cash flow results because hospitals pay low principal amounts in the early years of debt payback while receiving relatively high Medicare depreciation payments. Thus, hospitals have the incentive to make unnecessary capital investments to increase cash flow in order to maintain solvency.

In addition, since payment for operating expenses through PPS is directly related to patient volume, the presence of cost-based reimbursement for capital may actually foster substitution of capital for labor costs.

By contrast, our new proposal would promote administrative simplicity, flexibility for hospital management, and above all, greater incentives for improved efficiency.

Once hospitals are paid a single rate for both capital and operating costs, hospitals will have the flexibility to make their own determinations as to whether or not there should be any substitution of capital for labor. No longer would the cost-based system of payment influence the hospital's choices. The business decisions made under the proposed system would be based entirely on efficiency incentives.

In addition, consistent with congressional intent, the proposal would encourage prudent investment decisions, sensitive to market conditions. It would prompt the evaluation of cost-effectiveness of capital investments resulting, we believe, in improved efficiency.

Let me highlight the major aspects of our proposal.

Consideration of ProPAC's recommendations and continued analysis by our research staff have convinced us that splitting capital-related costs into two components is appropriate: plant and fixed equipment; and movable equipment. This decision was based on the fact that plant and fixed equipment, which usually represents about 60 percent of the average hospital's capital investment, is depreciated on a much longer cycle than movable capital equipment. Therefore, in phasing in capital payments, we are proposing a 10-year transition for plant and fixed equipment—quite a long period—and a 2-year transition for movable equipment.

We are proposing to use a blended capital payment amount during the transition, based upon a hospital-specific portion and a Federal portion. We recognize that some hospitals, having made recent large capital investments, are in a very early phase in their capital cycles. Therefore, the transition blend between Federal and hospital-specific portions will continue hospital-specific reimbursement in the early years.

In fact, we have weighted the actual cost of the transition for fixed and plant equipment so heavily toward the hospital's actual costs that, for the first 3 years of the transition, more than 80 percent of Medicare's share of the hospital's actual fixed costs are paid for, as they are currently determined. Moreover, for the first 7 years, more than 50 percent of Medicare's share of the hospital's actual fixed costs would continue to be reimbursed. This will smooth the transition from cost reimbursement to prospective payment for capital, and it will eliminate the need for grandfathering of current hospital capital obligations.

The Federal payment rates for plant and fixed equipment and movable equipment would be based on 1984 costs trended forward

to fiscal year 1988 by an estimate of actual Medicare capital cost increases, standardized as required by law.

Under the requirements set forth in OBRA, the capital payment rates will be budget-neutral for fiscal year 1988 and 1989. Beginning with fiscal year 1990, the rates will be increased annually by the prospective payment update factor, which would include a component for capital costs.

The hospital-specific portion of payments will be based on actual capital costs incurred during each year of the transition. This is being termed the so-called "rolling base," and we believe it will further ease the conversion from a cost-based to a prospectively paid capital payment system. I would also like to point out that no annual update procedure will be necessary for hospital-specific portion since the hospital-specific payments will be based on actual costs.

We believe our proposal for incorporating capital into the prospective payment system is a very reasonable and equitable approach that solves a number of the questions that were raised over the last year—primarily the question of "grandfathering."

Including a grandfathering provision for hospitals would assist hospitals that have recently capitalized at the expense of hospitals which intend to make capital investments in the next few years. We believe it is inequitable to pay hospitals on a significantly different basis depending on whether they happen to have invested before or after a fixed point in time. This policy would tend to penalize hospitals that prudently deferred their investments until absolutely necessary.

We believe that by placing heavy emphasis on the hospital-specific portion of capital payment in the early years of the transition, we are effectively providing special treatment for hospitals which have recently made large capital investments. We believe the transition will protect hospitals with high capital costs from undue reductions in payments while ensuring that hospitals with low current hospital costs will receive sufficient funds to meet future capital needs.

Finally, I think it is important to view the impact of our capital proposal in the context of total inpatient hospital payments. Medicare represents about 40 percent of inpatient services, and we assume that Medicare capital payment to hospitals is, on average, about ten percent of total Medicare payments. When considering outpatient and other hospital services in the impact analysis, the reduction is further reduced.

In summary, we believe it is time to incorporate Medicare capital costs into the prospective payment system. We want the successes of the prospective payment system to be experienced in the capital payment as they have been in operating costs. The management improvements made by hospitals as they develop more cost effective methods for providing services are just as possible in the area of capital as they were in the other PPS programs.

I believe that HCFA and the Congress today have a historic opportunity—and actually a responsibility—to act in this area. The policies that we are developing are reasonable and appropriate, and we believe are the best first step towards efficient use of limited capital resources.

Frankly, if we are to wait for some years into the future and accept the hospital industry's proposal of continuing the moratorium, I would say that you will have in the future all of the same problems that you have today; as a matter of fact, those problems probably will be exacerbated as hospitals rush to guess as to exactly what the Congress' and the administration's policy will be.

I urge you to work with us to perfect a capital policy, and that we work together to move forward and bring about the prospective payment for capital and put these two systems together in one whole, as Mr. Stark mentioned.

Thank you. I will be glad to respond to any questions you might have.

[The prepared statement follows:]

STATEMENT OF C. ROSS ANTHONY, PH.D.
ASSOCIATE ADMINISTRATOR FOR PROGRAM DEVELOPMENT
HEALTH CARE FINANCING ADMINISTRATION
MAY 4, 1987

Mr. Chairman and members of the Subcommittee, I appreciate the opportunity to appear before you today to present our proposal for including capital payments in the hospital prospective payment. The regulation describing our proposal will be published in the next few weeks.

Background

When PPS was enacted in 1983, capital costs were viewed as sufficiently different from operating costs that Congress excluded capital-related expenses from PPS. Capital costs therefore are treated separately, and continue to be reimbursed on a reasonable cost basis.

In compliance with the original statute, we published a notice of proposed rule making in 1986 proposing a prospective payment policy for capital. However, with the passage last July of the Urgent Supplemental Appropriations Act, the implementation of an all-inclusive hospital rate was postponed until October 1, 1987.

Since the implementation of PPS, Medicare capital costs per case have grown at about 15 percent per year. To contain capital growth until an all-inclusive rate could be implemented, the Omnibus Reconciliation Act (OBRA) of 1986 reduced Medicare capital payments for fiscal years 1987, 1988, and 1989.

We are now proposing a change in Medicare payment policy for hospital capital which is very different from last year's proposal. It is the product of extensive study as well as consultation with ProPAC and members of the industry. We believe the change we are proposing in Medicare payment policy for hospital capital is a useful next step for attaining the efficiency and quality goals of the prospective payment system. It is also a more rational and less interventionist role for government as the major payor for hospital services.

Current Cost-based Capital Reimbursement System

Medicare cost reimbursement for capital reflects a number of components such as the hospital's financing costs for capital and the value of its current assets.

Historically, cost-based reimbursement has paid hospitals for their capital investments based on Medicare's proportionate share of inpatient services. Unlike the prospective payment system, Medicare's current approach to paying for capital costs is insensitive to volume and is dependent, rather on merely the proportion of Medicare beneficiaries using hospital services. For example, if a three-hundred bed hospital has half of its beds filled by Medicare patients and half of its beds filled by non-Medicare patients, Medicare will pay approximately 50 percent of the hospital's total post-OBRA capital expenses. On the other hand, if the same three-hundred bed hospital has one-quarter of its beds filled by Medicare patients, and no beds filled by non-Medicare patients, Medicare will pay all of the hospital's post-OBRA capital expenses. Thus, in this example, while Medicare utilization of hospital services has declined, Medicare capital payments have increased.

In fact, over the past few years, as hospital occupancy rates have declined, Medicare has continued to reimburse hospitals based upon total occupied beds. In essence, Medicare's capital reimbursement system is subsidizing hospitals for empty beds.

Furthermore, the current cost-based system for Medicare's payment of capital costs gives hospitals very little incentive to purchase capital efficiently. In fact, the Medicare cost-based capital system, which, after OBRA, pays a hospital for almost its

entire share of Medicare interest and depreciation expenses, gives hospitals the incentive to increase their cash flow by investing in debt-financed capital. The increased cashflow results because hospitals pay low principal amounts in the early years of debt payback while receiving relatively higher Medicare depreciation payments. Thus, hospitals have the incentive to make unnecessary capital investments to increase cashflow in order to maintain solvency.

In addition, a drop in hospital patient volume may further encourage hospital managers to be negatively influenced by the dual system of payments we now have. Since payment for operating expenses through PPS is directly related to patient volume, the presence of cost-based reimbursement for capital may actually foster substitution of capital for labor costs.

Administration's Capital Proposal

By contrast, our new proposal would promote administrative simplicity, flexibility for hospital management, and above all, greater incentives for improved efficiency.

Once hospitals are paid a single rate for both capital and operating costs, hospitals will have the flexibility to make their own determinations as to whether or not there should be any substitution of capital for labor. No longer would the cost-based system of payment influence the hospital's choice. The business decisions made under the proposed system would be based entirely on efficiency incentives.

In addition, consistent with Congressional intent, the proposal will encourage prudent investment decisions, sensitive to market conditions. It would prompt the evaluation of the cost-effectiveness of capital investments resulting, we believe, in improved efficiency.

Let me highlight the major aspects of our proposal.

Consideration of ProPAC's recommendations and continued analysis of our own research have convinced us to split capital-related costs into two components: plant and fixed equipment, and movable equipment. This decision was based on the fact that plant and fixed equipment, which usually represents about 60 percent of the average hospital's capital investment, is depreciated on a much longer cycle than movable capital equipment. Therefore, in phasing-in capital payments we are proposing a ten-year transition for plant/fixed equipment, and a two-year transition for movable equipment.

We are proposing the use of a blended capital payment amount during the transition period made up of a hospital-specific portion and a Federal portion. We recognize that some hospitals, having made recent large capital investments are in a very early phase of their capital cycles. Therefore, the transition blend between Federal and hospital-specific portions will continue hospital-specific reimbursement in the early years. In fact, we have weighted the actual costs of the transition for fixed/plant equipment so heavily towards the hospital's actual costs, that for the first three years of the transition, more than 80 percent of Medicare's share of the hospital's actual fixed costs, as they are currently determined, would be reimbursed. Moreover, for the first seven years, more than 50 percent of Medicare's share of the hospital's actual fixed costs would be reimbursed. This will smooth the transition from cost reimbursement to prospective payment for capital, and will eliminate the need for grandfathering of current capital obligations.

The Federal payment rates for plant and fixed equipment, and movable equipment would be based on FY 1984 costs trended forward to FY 1988 by an estimate of actual Medicare capital cost increases, standardized as required by law.

Under the requirements set forth in OBRA the capital payment rates will be budget neutral for FY 1988 and FY 1989. Beginning with FY 1990, the rates will be increased annually by the PPS update factor, which would include a component for capital costs.

The hospital-specific portion of the payments will be based on actual capital costs incurred during each year of the transition. This is being termed a "rolling base" and we believe it will further ease the conversion from a cost-based to a prospectively paid capital payment system. I would also like to point out that no annual update procedure will be necessary for the hospital-specific portion since the hospital-specific payments will be based on actual costs.

We believe our proposal for incorporating capital into PPS is a very reasonable and equitable approach that solves a number of questions that were raised in the last year -- primarily the question of "grandfathering".

Including a grandfathering provision for hospitals would assist hospitals that have recently capitalized at the expense of hospitals which intend to make capital investments in the next few years. We believe it is inequitable to pay hospitals on a significantly different basis depending on whether they happen to have invested before or after a fixed point in time. This policy would tend to penalize hospitals that prudently deferred their investments until absolutely needed.

We believe that by placing heavy emphasis on the hospital-specific portion of the capital payment in the early years of the transition, we are effectively providing special treatment for hospitals which have recently made large capital investments. We believe the transition will protect hospitals with high capital costs from undue reductions in payments while ensuring that hospitals with low current capital costs will receive sufficient funds to meet future capital investment needs.

Finally, I think it is important to view the impact of our capital proposal in the context of total inpatient hospital payments. Medicare represents about 40-percent of inpatient services and we assume the Medicare capital payment to a hospitals is about 10-percent of total Medicare inpatient costs. When considering outpatient and other hospital services in the impact analysis, the reduction is further reduced.

Conclusion

In summary, we believe it is time to incorporate Medicare capital costs into the prospective payment system. We want the successes of the prospective payment system to be experienced in capital payment as they have been for operating costs. The management improvement made by hospitals as they develop more cost effective methods for providing services are just as possible in area of capital.

I would like to again emphasize how critical it is that we maintain our momentum toward efficient use of limited resources. We believe the hospital industry is fully capable of making the necessary changes in their financing mechanisms, and the proposal I have described here today is the best first step toward accomplishing that goal.

Chairman STARK. Just to fill me in, Mr. Anthony, your 10-year transition starts from when?

Mr. ANTHONY. Fiscal year 1988.

Chairman STARK. It is my understanding that every hospital administered by a person who could read knew that, since 1983, we were going to discontinue paying capital retrospectively. Is that not correct? Everybody was on notice?

Mr. ANTHONY. The Congress put everybody on notice in 1983 that they would be moving to a prospective payment system for capital. So in actual fact, you can say that hospitals will have had the 10 years of the transition we are proposing, in addition to 5 additional years to adjust to these changes.

Chairman STARK. A free ride, in a sense. This is coming as no surprise to anyone.

Mr. ANTHONY. Yes.

Chairman STARK. Now, have you considered, I guess the right word might be outlier? In other words, we talked about last year dealing with folks who had not gotten into the program in 1983 because the architect did not get the plans or the bond counsel could not get a blue sky and so they missed the 1983 date. But that is no longer necessary under your proposal, is that it? Does it make any difference whether you got on board before 1983 or after 1983?

Mr. ANTHONY. No. We do not believe that there is a need for an outlier policy today. I say that for a number of reasons. We changed our transition so that our transition is so long and that it is weighted early on very heavily towards hospital-specific that we just do not think that there is a need for a hospital-specific outlier policy. Now, let me distinguish that between——

Chairman STARK. Let me just say it another way. How is it weighted in the first 3 years? How much of the capital recovery will there be of the total 100 percent?

Mr. ANTHONY. In the first 3 years, there will be 80 percent of the actual hospital-specific costs would be covered.

Chairman STARK. No, let us talk about recovered.

Mr. ANTHONY. Oh, I see what you are saying.

Chairman STARK. You see what I am saying? Let us assume you have got a $10,000 mortgage, principal and interest. Are you front-end loading it so much that they will be getting half of the capital expenditure back in the first 3 years?

Mr. ANTHONY. I think that is rather hard to answer. It depends upon when they have made these investments. But the system is designed so that over a period of time the hospitals are able to make the kinds of decisions they need to make to build up capital in anticipation of what their capital needs would be.

We think that about 50 percent on average will be passed through in the first 3 years and 50 percent will be under the Federal rate.

Chairman STARK. Did you concern yourself with all the hospitals that have suggested to me that they are going to go broke and have to close if anything at all gets done but the moratorium? And there have been some small rural hospitals and some inner city hospitals, a variety of different hospitals with different patient mix and different situations have just suggested to me that they will absolutely have to go out of business. Have you looked into those? Have

you found any that you think will go bankrupt in your studies, and what are you going to do to help them?

Mr. ANTHONY. Again, I am sorry we cannot give you all of our final numbers. We are in the last stages of finishing our policy and running all those numbers. But I can say to you that our preliminary analysis indicates that, in fact, the number of those hospitals is really quite small.

It is really hard to anticipate what would happen after a 10-year transition. Again, let me point out, and emphasize, that most of a hospital's own hospital-specific costs are paid for, for a long period of time, 50 percent after 8 years.

Hospitals have a long period of time to adjust. It is not quite certain as to what the prospective payment update factors will be, so we cannot anticipate exactly what will happen.

All we know is that when we implemented the prospective payment system that, as you will recall, the hospitals said a lot of the same things, and yet today we have found that the profit margins have certainly continued to be positive.

I know that ProPAC has done an analysis, and they found that their vulnerability factor, as they indicated, is only about 3 percent. That is really quite a small number of hospitals.

Chairman STARK. Isn't it the case, that even if a hospital came into see you, and said that we are going to go broke if this goes into effect, that you would have no way of ascertaining whether they were telling you the truth, or not, except to take their figures. And we do not have any figures to really tell whether the hospital is telling the truth, or not, do we?

Mr. ANTHONY. We have cost reports, but we do not have actual numbers to be able to really tell.

Chairman STARK. Wouldn't your job, and thereby mine, be a lot easier if you had, as California does, a mandatory reporting system, so that if hospital X came in to see you, you could just look back, and explain to them—so you know as well as they know why they are going to go broke?

Mr. ANTHONY. Well, I know that——

Chairman STARK. Don't you delight in your work?

Mr. ANTHONY. I know that you have been interested in such data, and, quite frankly, I will tell you that, as a policy official, I wish I had better data, and I wish that it took less time for me to get it than it does.

We have tried to look at this in consideration of—not only the data and the information that we get, how quickly we get it—but also, the burden that it puts upon the industry.

And as we have weighed those factors together, we have always tried to move forward to have better data and information. I would not say it is ideal, but we continue to work on that proble[illegible]

Chairman STARK. Thanks. Mr. Gradison.

Mr. GRADISON. Thank you, Mr. Chairman.

When this proposal was first made, it was my understanding that the objective of the administration was to slow the flow of capital into the hospital industry because of overbedding, rising vacancy rates, and so forth.

In many respects, that has already happened for a variety of reasons. Vacancy rates are higher, interest rates are higher, some of

the advantages of issuing these bonds may not be there as they were before.

We are not, under Medicare, paying the whole freight any more. We have already provided, under law, to reduce the payments from what would be shown in the cost reports by 3½, 7, and 10 percent.

Why don't we just declare victory and go home, and maintain these percentages? Seriously. I mean, looking at the hospital industry as a whole, do we need to get into this kind of a complex formula, or could we handle it by the "rough justice" of just extending the 3½, 7, 10, and no doubt it is somewhat higher, into subsequent years?

Mr. ANTHONY. First of all, let me say the administration's goal is not necessarily to slow the amount of funds going into capital.

What we are interested in is efficiency and appropriate investment decisions. And certainly, we are interested in that efficiency ultimately reflecting the amount of payments that we make.

But what happens with a cost-based reimbursement system is, frankly, you do not have the incentives of the hospital industry to be efficient, and that is well known by most people.

In addition to that, there is an incentive to substitute capital for labor, to hire more people and have less capital. All of those aspects in the system lead to inefficiency.

What we are interested in creating is a good system that leads to efficient utilization of resources, and consequently, uses dollars and provides the best high-quality service to beneficiaries it is possible to create.

Mr. GRADISON. Well, you focused in your testimony—and I understand that, and I can think of all kinds of sound theoretical reasons to incorporate this into the other payment. I am particularly concerned about the——

Mr. ANTHONY. Let me mention——

Mr. GRADISON [continuing]. Hazard of the substitution of capital for labor from an economic point of view.

Go ahead. I am sorry.

Mr. ANTHONY. I was just going to say, and I think it is a point that the chairman brought out earlier is: right now, we have two systems split apart, and that has caused problems. It makes much more sense, it seems to me, to mold those systems together, to have one prospectively paid system for hospital services.

Mr. GRADISON. Well, you emphasized in your testimony this afternoon the empty beds. Couldn't we deal with that without getting into a complex formula like this?

Take the case you mentioned of the hospital that has 25 of its 100 beds occupied by Medicare beneficiaries, and no one else. We pay 25 percent. I mean, wouldn't that take care of it without having to go into all of this complex arithmetic?

Mr. ANTHONY. I would make two points. One, you could have some kind of an occupancy adjustment to your payment formula. That has been discussed, and certainly, that is theoretically possible.

But rather than getting caught up in that, I would like to go back to the incentives, and the reason for creating the system in the first place.

And frankly, I do not think the math is very complicated. We are going from 95 to 90, to 85, et cetera, and it is a fairly reasonable, rational system that will not be hard to implement.

Mr. GRADISON. We have on the books, now, and I believe we use as a basis for measurement of any proposal, the budgetary impact of any proposal, the 3½, 7, and 10. Have you made any projections as to what those reductions would be, if extended beyond the third year on the same assumption that we were attempting, through an across-the-board cut to achieve the same dollars savings, which your proposals have assumed?

Mr. ANTHONY. And as a matter of fact, our proposal is to continue the 10-percent reduction that Congress enacted into 1990, 1991, and 1992, and I could give you the preliminary estimates as to what those savings would be.

Mr. GRADISON. Yes.

Mr. ANTHONY. In 1990 it would be $520 million; 1991, $660 million; and in 1992, $760 million. That is if you continue that 10 percent reduction into the out-years.

Mr. GRADISON. Okay. Let me ask it another way. If we were to do just what you were recommending today, are those the dollar savings which we would achieve in those years, or is it something more?

Mr. ANTHONY. It is primarily that, as a matter of fact.

Mr. GRADISON. So your savings, bottom line, are roughly equal after the third year for a while, for a few years after that, to the 10 percent across the board? Is that correct?

Mr. ANTHONY. Of course it is not across the board, but it results in some sense——

Mr. GRADISON. Well, ours would be. I mean, the statutory requirements.

Mr. ANTHONY. Yes. If you had an across-the-board reduction, you would simply continue that without the prospective payment system. It is my understanding the savings would be similar.

Mr. GRADISON. About the same?

Mr. ANTHONY. I guess I should also point out, that continuing that 10-percent reduction would require legislation, and we would ask Congress that that legislation be passed.

Mr. GRADISON. I understand that. One of the main complaints that I received the last time around on this was that your proposal had not been tested against categories of hospitals and specific hospitals.

Have you filled that gap? Can you give us, if not now, soon, a breakdown for different types of hospitals? Rural, urban, rural-rural-rural, urban-rural, and all that stuff? [Laughter.]

Mr. ANTHONY. We will even give you rural-rural-rural, if you want it. I am really sorry that I do not have those numbers for you today. We tried very hard to get the proposal finished, completed, so we could give you that information.

In the next few weeks, I would be glad to submit all those impact analyses for the record, and I would be glad to personally bring them over to you and discuss them with you, and any members of your staff that you might wish.

We are doing that type of analysis, and I would project that in a few weeks, that you will have that information.

[The following was subsequently received:]

Overall, rural hospitals fare better than urban hospitals. Rural hospitals with fewer than 50 beds do especially well, showing on average, a 1.3 percent increase in payments. On the whole, payments to rural hospitals show a 0.1 percent average increase compared to an insignificant decrease of less than 0.05 percent in payments for urban hospitals.

In general, reductions in FY 1988 payments do not necessarily mean losses for hospitals. For example, a noncash expense, such as depreciation, may cause a hospital to show an accounting loss, but does not affect cash flow.

TABLE I--ESTIMATED IMPACT OF THE FIRST YEAR PAYMENT BLENDS OF FEDERAL AND HOSPITAL-SPECIFIC PAYMENTS FOR FIXED AND MOVEABLE CAPITAL COST IN FY 1988 COMPARED TO ESTIMATED IMPACTS OF THE FIRST YEAR BLEND AS PROPOSED MAY 19, 1987 1/

	Number of Hospitals 2/	Fixed - 5% Federal Moveable - 33% Federal (PROPOSED PAYMENT RATES) 3/	Fixed - 5% Federal Moveable - 5% Federal (FINAL PAYMENT RATES) 4/
All Hospitals	4820	0.0	0.0
Urban by Region			
New England	174	5.0	1.5
Mid Atlantic	280	2.6	0.8
South Atlantic	382	-1.1	-0.2
East North Central	483	0.2	-0.1
East South Central	157	-1.9	-0.5
West North Central	188	-0.7	-0.2
West South Central	338	-1.5	-0.5
Mountain	91	-2.9	-0.8
Pacific	461	-1.0	-0.2
Rural by Region			
New England	30	5.0	2.0
Mid Atlantic	86	4.0	1.2
South Atlantic	301	1.0	0.0
East North Central	351	0.4	0.0
East South Central	294	0.4	0.1
West North Central	512	0.7	0.1
West South Central	404	0.5	0.0
Mountain	145	-0.7	-0.3
Pacific	89	1.6	0.1
Urban Hospitals	2554	-0.2	0.0
0-99 Beds	627	0.3	0.0
100-404 Beds	1561	0.9	-0.3
405-684 Beds	308	1.2	0.4
685 + Beds	58	1.0	1.0
Rural Hospitals	2212	0.9	0.1
0-99 Beds	1694	2.3	0.5
100-169 Beds	347	-0.2	-0.2
170 + Beds	171	0.4	0.1
Teaching Status			
Non-Teaching	3824	-0.6	-0.3
Resident/Bed Ratio Less than 0.25	794	0.3	0.2
Resident/Bed Ratio 0.25 or Greater	148	3.3	1.1

Table I - continued

	Number of Hospitals 2/	Fixed - 5% Federal Moveable - 33% Federal (PROPOSED PAYMENT RATES) 3/	Fixed - 5% Federal Moveable - 5% Federal (FINAL PAYMENT RATES) 4/
Disproportionate Share Hospitals (DSH)			
No Additional Payments	3691	-0.3	-0.1
Urban DSH 100 Beds or More	793	0.5	0.2
Urban DSH fewer than 100 Beds	82	1.4	-0.4
Rural DSH	200	4.8	0.4
Other Special Status			
Rural Referral Centers (RRCs)	196	1.5	0.2
Rural fewer than 50 beds	983	5.6	1.3
Type of Ownership			
Voluntary	2868	0.4	0.1
Proprietary	712	-4.2	-1.1
Government	1165	3.3	1.1

1/ This table represents estimated Medicare margins for the Federal/hospital-specific payment blend for fixed and moveable capital costs for the first year of the transition from the present capital payment system to the prospective payment system compared to Medicare margins that were estimated based on the prospective payment rates for fixed and movable equipment proposed in the May 19, 1987 proposed rule as corrected by the June 11, 1987 notice. These margins result from a comparison of projected payments under the new payment system to payments under the current system, based on 1984 data inflated through FY 1988, and assumes all hospitals have cost reporting periods corresponding to the beginning and end dates of the phase-in year. Both sets of margins reflect a budget neutrality factor based on projected FY 1988 payments and the exclusion of sole community hospitals from the proposed payment system.

2/ This column shows the number of hospitals in each cell of the FY 1984 hospital cost data base used to compute both the proposed payment rates and the estimated impact. Puerto Rican hospitals are only included in the national hospital total of 4820; otherwise, Puerto Rican and sole community hospitals are not included in these figures.

3/ Margins based on a blend of 95 percent hospital-specific for plant/fixed equipment, and 67 percent hospital-specific portion for the moveable equipment that was proposed in the May 19, NPRM, as updated by revisions to the notice published on June 11, 1987.

4/ Margins based on a blend of 95 percent hospital-specific portion for both plant/fixed equipment, and moveable equipment.

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Mr. GRADISON. Well, I am happy to hear that. Frankly, I thought one of the problems the last time around, when you did not have it, is that there were no winners stepping forward and saying go with this change. It would be better off than something else. Now we know what the "something else" is, at least for the next 3 years. It is the 3½, 7, and 10. I mean, I assume that that is where we are starting from.

And it would seem to me to be in your own interest not just to get those figures to us but to the industry as a whole, to see if there are any sinners that would come forward and support your proposal.

They just did not come out of the woodwork before.

Mr. ANTHONY. I could not agree with you more.

Mr. GRADISON. Thank you. Thank you, Mr. Chairman.

Chairman STARK. Mr. Levin.

Mr. LEVIN. Thank you. Let me just be clear, following up Mr. Gradison's question, or, was it Mr. Stark's. If there were a shortage of hospital beds in America today, would you be proposing the same change?

Mr. ANTHONY. Yes, because that really does not basically change the fact that what we are trying to do is create a system that has proper payments to promote efficiency.

In actual fact, when there are shortages, what tends to happen is the economic forces tend to adjust for that.

Mr. LEVIN. All right. So, it really is regardless, unrelated to any surplus of hospital beds?

Mr. ANTHONY. Let me just follow up on the——

Mr. LEVIN. Because I think that is a question, really, of some significance.

This system is based on projections. I think we want to look at the projections in view of recent developments.

Mr. ANTHONY. In actual fact if the number of Medicare patients grew in proportion to the other patients, using my example the other way, you will actually find that Medicare payments would go up, as would be—in this sense—appropriate.

And I think it is also important to realize that the prospective payment update is designed to take into account, and would take into account, this kind of additional need of capital in a situation which you might be speaking of.

In actual fact, though, we do have a surplus of hospital beds today. We do not have a great need, as we maybe once did.

Mr. LEVIN. At the moment.

Mr. ANTHONY. Yes.

Mr. LEVIN. Okay. Secondly, it is not clear to me, when you institute the new system, how much is saved over the next period of time in contrast with if the system is not instituted? What is the savings?

Mr. ANTHONY. The Congress has mandated in fiscal years 1988 and 1989, which this proposal would cover, a 7 and a 10 percent reduction.

Mr. LEVIN. Yes, but beyond that, you propose to institute it not only for equity of payment within the system, but for reducing the cash flow in future years beyond the next few years, right?

Mr. ANTHONY. Yes. But, you know, our proposal in 1988 and 1989 has the same savings that yours has by law——

Mr. LEVIN. Right.

Mr. ANTHONY [continuing]. So it is budget-neutral in relation to those.

Mr. LEVIN. Right.

Mr. ANTHONY. In the out-years there would be the savings that I gave you earlier, which would require an additional legislative proposal.

Mr. LEVIN. All right. But you are saying that in out-years, 1990, 1991, and 1992, the savings would be the same as if we continued what is now in the law for those subsequent 3 years? Is that correct?

Mr. ANTHONY. That is correct, but even if you desired that to be the case, you also would have to tell us in law. Right now, the law only covers through 1989.

Mr. LEVIN. Right. But the savings would be the same under what you propose, and under a system where we continued the reductions for three subsequent years, at what levels?

Mr. ANTHONY. At the 10 percent level is what we——

Mr. LEVIN. A flat 10 percent.

Mr. ANTHONY. They are similar.

Mr. LEVIN. So if we just maintain the 10 percent in 1990, 1991, and 1992, the impact on the budget would be the same as under your system?

Mr. ANTHONY. It would be very similar.

Mr. LEVIN. So——

Mr. ANTHONY. But let me emphasize what you really would lose then is the behavioral aspect. Under our proposal you will begin to get hospitals used to adjusting to a new system that is prospectively paid. I cannot tell you exactly how they will adjust, but our anticipation is they will make much more rational, better capital investment decisions. In the long-run, the Congress and the American people will be able to reap the rewards of that kind of efficient investment.

Mr. LEVIN. All right. Next, does the proposal take into account, in terms of its payment system, differentials in cost of construction by——

Mr. ANTHONY. That is an issue that we are looking at, and I am not quite sure how the final regulation will read, but I think that is something that we are, and we should look closely at.

Mr. LEVIN. Well, let me press you on that, because it seems to me more than kind of tertiary, no? Construction costs vary dramatically. I would guess, in some respects, more dramatically than hospital costs.

In other words, the differences are not just rural-rural, urban-urban, et cetera, et cetera, right?

Mr. ANTHONY. That is correct.

Mr. LEVIN. They reflect other factors, and any formula that does not take into account dramatic differences in construction costs is likely to have a lot of built-in inequities, right?

Mr. ANTHONY. I think you are correct, that there are large geographic differences in the amount it costs to construct a hospital building.

Mr. LEVIN. Now how do you expect us to react to a proposal until we see how it reacts to that kind of a factor among others?

Mr. ANTHONY. I certainly think that you, as Members of the Congress, should take a look at the entire proposal. I indicated at the end of my statement, in all of this proposal that will be coming out shortly, we have tried to be flexible and reasonable, and give hospitals a chance to adjust, and create a good system.

And let me emphasize that. We want to work with the Congress; we want to work with other people to hone this proposal, and make it work for everyone. And so we look forward to the comments, and we quite honestly have solicited those in many different places.

Mr. LEVIN. All right, sir. But before you actually initiate, launch the proposal, you will finish your work on cost differentials, and that will be incorporated in the proposal, right?

Mr. ANTHONY. We are looking at that closely, and we have done a lot of work on that, and——

Mr. LEVIN. You mean you might launch a proposal without resolving that issue?

Mr. ANTHONY. No, there will be some mention of a construction cost index in the regulation.

Mr. LEVIN. Okay. These are not questions from somebody who is unsympathetic with your objection, but I think we might as well be realistic about some of the problems.

My last question, if I might ask you an unfair one, anticipating further discussion. Unfortunately, we have to go seriatim.

What is the strongest argument against your proposal? I mean, you have been working on it for 3 or 4 years.

Mr. ANTHONY. I hate to be immodest, but I really do not think there is a good argument against it.

Mr. LEVIN. What is the best of the bad arguments, then, or maybe you do not want to——

Mr. ANTHONY. I think that, if I wanted to argue against myself, what would give me the most trouble is, frankly, the individual hospital that is in your district which says, "Gee, I will get hurt."

That question that was brought up earlier. And, inevitably, in a system like this, you will have some hospitals that will not fare as well as others, and those hospitals will come to you, and speak loudly, and what you will see is the one hospital that gets hurt, but you will not see the 7, 8, or 9 hospitals that actually are helped, or have a fair, say, level playing field, where they have an opportunity to compete in a marketplace and achieve savings that they can apply to other programs and help Medicare beneficiaries.

My guess is that that is the kind of influence and pressure that will be brought to bear on you. We hope that the Congress is able to see past the individual situations, and make an overall decision. As I said earlier, I honestly do view this as an historic opportunity to make good policy, and I hope that we all can work together to bring that about.

Mr. LEVIN. Thank you, Mr. Chairman. The reference to "level playing field" has some echoes from last week. Thanks very much.

Chairman STARK. Mr. Pickle.

Mr. PICKLE. Mr. Chairman, I do not have any specific questions. You seem to indicate that your recommendations would result in a

savings. I would like to know more specifically what kind of savings you would expect if we were to go to this new system.

It would not be an immediate savings. It would be down the line. I am certain of the fact that hospital capital spending has been declining, and that we also made cuts this last year.

I do not understand why you are advocating this change, when it does not have an impact on revenue, other than possibly by improving efficiency. Now we are proposing to try to measure efficiency in order to satisfy you and HCFA that hospitals meet some standard of being efficient, along with meeting capital cost rules.

I have to look at this issue in relation to my own district. The State of Texas is not issuing these certificates of need any more, and many States have gotten out of this practice.

If we were to blend in the operating costs in with the DRG's, then you would require States to reinstitute the certificate of need, would you not?

Mr. ANTHONY. No, you would not. As a matter of fact, we would tend to agree with the hospital industry that we would want to not go back to the 1122 system.

Mr. PICKLE. I do not see that anywhere in your remarks. Is that a part of your testimony?

Mr. ANTHONY. It is not in the testimony, but that issue would have to be addressed, and is addressed in the regulation.

Mr. PICKLE. Well, how do you address that issue, then?

Mr. ANTHONY. Well, the administration opposed a Federal health planning system, as you are well aware. We continue to feel that that is not an appropriate way to go. Once we have capital phased into the prospective payment system, we would like to move away from that issue.

Mr. PICKLE. Well, I would ask you more specifically, assuming that this change is made, and you were to force States to reinstitute this certification which you say will not hurt them, will there not be additional reductions in the program?

Mr. ANTHONY. I am sorry. I did not understand your question.

Mr. PICKLE. Well, States that are subject to section, what is it? 111?

Mr. ANTHONY. 1122.

Mr. PICKLE. 1122. My question to you is, will reinstituting the requirements in that section result in additional reductions in the overall operating costs?

Mr. ANTHONY. We would not see them subjected to 1122. They would have to conform with the regulation we put into place, but we would not anticipate that that would build on top of 1122.

Mr. PICKLE. Well, over and above efficiency, I assume you are trying to—as Mr. Gradison said—slow down the flow of capital to any hospital. That situation is taking care of itself. There are 15 or more hospitals in my State that have already gone out of business, and I have some in my district which have made considerable investments in the last 2 or 3 years.

Now would they not be affected? If I understood you, you said yes, they would be, but 80 percent of the hospitals would be helped, and the others would not be hurt because they would have a favorable transition. But I understand you do not want a grandfather provision?

Mr. ANTHONY. We do not want a grandfathering provision. We do not think that is necessary, and what you are going to find is that hospitals are going to be paid a fair amount for their capital. Most of the payment is weighted toward the hospital-specific portion in the early years, and as a result will have not a huge consequence.

The incentives will be put into the system, and hospitals can make long-term decisions on how they want to allocate their capital expenses.

If you grandfather, what you are going to end up doing is advantaging those hospitals which have made large, recent capital expenditures——

Mr. PICKLE. Putting it another way, you do not want to give them an advantage; you just put them out of business.

Mr. ANTHONY. Well, in actual fact, I think you do advantage them in this way: You pay for their capital, but the system has to be budget-neutral. You in Congress have told us that. That money has to come from some place, and where it comes from is the payments to other hospitals.

By having a long transition that is weighted towards the hospital-specific payments in the early years, you really give hospitals the opportunity and the chance to adjust, and that is the key.

They need the opportunity, quite rightly, to adjust.

Mr. PICKLE. Well, do you think this will affect the rural hospital?

Mr. ANTHONY. Yes, I think it will affect all hospitals, and although, again, I do not have the exact numbers for you, I can tell you that our preliminary figures show that rural hospitals do quite well under this system.

Mr. PICKLE. Well, that may be. I have not heard from the rural hospitals. I have been hearing from my own hospitals, and they do not have any strong unanimity of feeling that your proposal will create simplicity and efficiency. They say it is going to cut their plans back considerably, and so naturally, they are affected by it.

Thank you, Mr. Chairman.

Chairman STARK. Thank you for your testimony, and your answers to our inquiry. It was very helpful, Mr. Anthony, and we will look for your return in the near future.

Mr. ANTHONY. I do appreciate the opportunity. Thank you, sir.

Chairman STARK. Our next witness is Hal Cohen, the chairman of the Subcommittee on Hospital Productivity, and in my notes it says "Cozy Effectiveness" but I think that was supposed to be "Cost Effectiveness," of the Prospective Payment Assessment Commission. Welcome to the committee, Dr. Cohen.

We are going to give you 5 minutes to summarize, or expand on your testimony in any way you are comfortable, and then we will get into it in more depth as the committee inquires. Please proceed.

STATEMENT OF HAROLD A. COHEN, PH.D., CHAIRMAN, SUBCOMMITTEE ON HOSPITAL PRODUCTIVITY AND COST EFFECTIVENESS, PROSPECTIVE PAYMENT ASSESSMENT COMMISSION (ProPAC), AND EXECUTIVE DIRECTOR, MARYLAND HEALTH SERVICES COST REVIEW COMMISSION, ACCOMPANIED BY BRUCE STEINWALD, DEPUTY DIRECTOR OF ProPAC STAFF

Mr. COHEN. Mr. Chairman, I appreciate your invitation to appear before the subcommittee to discuss ProPAC's recommendations regarding the inclusion of capital-related costs into the prospective payment system. I am accompanied today by Bruce Steinwald, the deputy director of the commission's staff.

Early on the commission developed principles to guide the development of our recommendations regarding a capital payment system.

I want to briefly state what those principles are. The first is to provide neutrality between capital and operating cost tradeoffs.

The second is to reflect capital intensity variations across the DRGs, and, the third is to contribute to controlling aggregate expenditures, and the level of capital payment.

With these principles in mind, ProPAC adopted a series of capital payment recommendations in its April 1986 report to the Secretary. This year, the commission has reaffirmed the majority of those recommendations, and has modified some. I will briefly summarize the commission's recommendations relating to capital.

The commission reaffirms its 1986 recommendation that the Secretary initiate a transition to a new capital payment system for hospitals.

The new system should combine operating and capital costs in a single prospective payment per case. The commission continues to believe that cost-based reimbursement for capital introduces distorted incentives for investment decisionmaking.

In particular, the current passthrough encourages hospitals to substitute capital for labor, or other operating costs, even when it is not the most efficient choice overall.

In addition, the current system fails to encourage hospital managers to evaluate interest rates or alternative financing mechanisms in making investment decisions.

The payment method should encourage hospital managers to choose the optimal mix of capital and operating inputs. The commission believes the capital payment system should distinguish between two components—fixed capital and movable capital.

This recognizes differences in the nature of fixed and movable capital purchases, and the incentives influencing hospital decisions for these components. The commission believes the Federal portion for capital payments should be a fixed percentage add-on to the standardized amount. That assumes that the DRG amounts continue to be charge-based.

Capital components would then be added to the hospital market-basket. In addition, the other components of PPS payments, such as indirect teaching and disproportionate share adjustments, should be recomputed to reflect the inclusion of capital costs when appropriate data become available.

In other words, as soon as possible, the whole system should be internally consistent, as it would have been if capital were included in the first place.

The commission modified its original recommendation regarding the level of Federal capital payment to recognize the spending limits established in OBRA of 1986, and we are recommending that that be the level.

The method established to make the OBRA reductions should not disproportionately affect one capital component more than another. In addition, the commission believes that it would be inappropriate to reduce capital payments in a further effort to account for the costs of excess capacity.

The commission has conducted several studies regarding its original proposal of a 7- to 10-year transition. We now believe the 10-year level transition for fixed capital is appropriate. The commission also modified its recommendation for movable capital, and now recommends a 3-year transition for movable capital.

I should identify that our 3-year movable transition is the same as the administration's 2 years. We just describe it differently.

The commission reaffirms its 1986 recommendation, that during the transition period, hospital-specific payment should be based on actual capital cost adjusted for OBRA 1986 reductions.

This will assist hospitals in meeting their debt obligations, and encourage cost-effective capital decisionmaking in the future.

Currently, Medicare does not reimburse capital costs incurred by Medicare inpatients for services provided by facilities other than the hospital receiving the DRG payment.

The commission believes Medicare should be institution-neutral by paying for the capital costs of inpatient services, regardless of who owns the capital.

For example, if you are an inpatient in a hospital, and you are sent down the street for a freestanding MRI——

Chairman STARK. What is an MRI?

Mr. COHEN. A magnetic resonance imaging machine. Medicare will not pay anything for the capital costs of that MRI because it does not show up on a Medicare cost report. Whereas, if the hospital owned it they would pay for it. And so there are distortions to put the capital inside hospitals.

The commission believes that that should be corrected. I see the red light is on, Mr. Chairman, so I will just rather briefly state that the commission has, as you have heard earlier, done extensive reviews on the need for an exceptions policy.

We believe very few hospitals would be harmed under a prospective payment system for capital as I have outlined. Those that would be harmed will not be harmed for a period of time, because at 90 percent of Medicare costs, for example, the hospital is still getting more than its cash flow requirements which are only about 80 percent of Medicare costs.

So the hospital is not driven into insolvency at all in the first several years. The jeopardy is later on, and there is plenty of time to adjust the system for that.

We think there are about 3.3 percent of hospitals that are eventually capital vulnerable.

In concluding, we believe the recommendations we advanced last year, with the modifications I suggested, are appropriate. We believe that paying hospitals under a cost-minus system, which is the current law, would unfairly penalize hospitals for reducing their capital expenditures, and have inappropriate incentives.

Thank you very much, Mr. Chairman.

[The statement of Dr. Cohen follows:]

Statement of Harold A. Cohen, Ph.D., Chairman,
Subcommittee on Hospital Productivity and
Cost Effectiveness, on Behalf of the
Propective Payment Assessment Commission

Mr. Chairman, I appreciate your invitation to appear before the Subcommittee to discuss the Prospective Payment Assessment Commission's recommendations regarding the inclusion of capital-related costs into the prospective payment system. I am accompanied today by Bruce Steinwald, Deputy Director of the Commission's staff.

When Congress enacted the prospective payment system, as a part of the Social Security Amendments of 1983 (Public Law 98-21), capital-related payments were to be included in PPS beginning in fiscal year 1987. However, as a part of the Urgent Supplemental Appropriations Act (Public Law 99-349), Congress decided to defer implementation of a new capital payment policy until fiscal year 1988. Until that time, capital-related costs are reimbursed on the basis of reasonable costs.

The Commission began examining the issue of capital payment in 1985. Early in its deliberations on capital payment, we developed principles to guide the development of our recommendations. These important principles, still endorsed by ProPAC, are that the capital payment system should:

- Provide neutrality between capital and operating cost trade-offs,
- Reflect capital intensity variations across the DRGs, and
- Contribute to controlling aggregate expenditures and the level of capital payment.

Other important attributes of a capital payment system include recognition of capital cost variations that are beyond the hospital's control; promotion of administrative simplicity and predictability; and support of the development and appropriate diffusion of new, cost-effective, capital-intensive technologies.

RECOMMENDATIONS FOR INCLUDING CAPITAL INTO PPS

With these principles in mind, the Commission adopted a series of capital payment recommendations in its April 1986 Report to the Secretary of HHS. This year the Commission reaffirms the majority of these recommendation but also recommends some modifications and refinements based upon our ongoing analysis of the capital payment issue. I will briefly summarize the Commission's recommendations relating to capital. A complete copy of the 1987 recommendations and accompanying discussion language is attached to my formal testimony, and I would ask that this be included in the record.

Including Capital in the Prospective Payment System

This year, the Commission reaffirms its 1986 recommendation that the Secretary initiate a transition to a new capital payment system for hospitals. The new system should combine operating and capital costs in a single prospective payment per case. The Commission continues to believe that cost-based reimbursement for capital introduces distorted incentives for investment decision-making. In particular, the current pass-through encourages hospitals to substitute capital for labor or other operating costs even when it is not the most efficient choice overall. In addition, the current system fails to encourage hospital managers to evaluate interest rates or alternative financing mechanisms in making investment decisions.

Therefore, we continue to believe that the payment method established should not favor either capital or operating costs. It should, instead, encourage hospital managers to choose the optimal mix of capital and operating inputs.

The Commission also believes that the capital payment system

adopted should distinguish between two components: fixed capital (buildings and fixed equipment) and moveable capital (moveable equipment). This method recognizes differences in the nature of fixed and moveable capital purchases and the incentives influencing hospital decisions for these components.

Capital Payment Method

The Commission reaffirms its 1986 recommendation that the federal portion of capital payments should be computed as a fixed percentage add-on to the standardized amounts. Capital components would then be added to the hospital market basket. In addition, the other components of PPS payment, such as indirect teaching and disproportionate share adjustments, should be recomputed to reflect the inclusion of capital costs when appropriate data become available.

An initial study on geographic variations in capital construction costs was conducted under contract for ProPAC. The results indicate that fixed capital costs vary substantially across the country. A complete summary of these findings is included in the Technical Appendixes to our April 1987 Report. The Commission will continue its analysis of geographic variations to determine what, if any, adjustment would be appropriate. In addition, the Commission will continue to study other implementation issues, such as whether the Secretary's use of charge-weights adequately reflects capital intensity variation across DRGs.

Level of Federal Capital Payment

The Commission modified its original recommendation regarding the level of Federal capital payment to recognize the spending limits imposed by Congress in the Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509). The Commission now recommends that capital payments should be established at spending levels consistent with those established by OBRA 1986. In addition, the Commission recommends that the levels for fiscal years 1988 and 1989 be based on official 1987 capital spending projections. These projections should include all capital components as presently determined on a reasonable cost basis.

In making the required OBRA 1986 reductions, the Commission believes that the method established by the Secretary should not disproportionately affect one capital component more than another. In addition, the Commission believes that it would be inappropriate to reduce capital payments further effort to account for the costs of excess capacity. It is our belief that the level of capital payment we propose provides hospitals with the appropriate incentives for reducing overall capital spending levels while affording them an opportunity to adjust their behavior accordingly.

Capital Payment Transition

The Commission modified its earlier recommendation regarding the capital payment transition. In the 1986 report, we suggested that there should be no transition for moveable capital and that payments for fixed capital should be phased in over a seven to ten year period on a straight-line basis.

During the past year, the Commission conducted additional analyses regarding the capital payment transition. We now recommend a ten-year transition be provided for fixed capital.

Fixed capital is purchased infrequently, involves major capital expenditures, and often requires external review. It is not easily converted to another use, and the related expenses cannot be eliminated in the short-term. Fixed capital financing typically requires the use of debt or additional equity.

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Furthermore, the time lag for purchase decisions, financing, and completion of fixed capital projects typically ranges from two to six years. For these projects, hospitals cannot respond as quickly to the incentives of a new payment system or to warnings about the future treatment of capital.

The Commission conducted an analysis to determine the effect of a seven- versus a ten-year transition period for fixed capital. These analyses indicated that a ten-year transition provided a broader group of hospitals with more financial protection. As a result, the Commission modified its earlier recommendation to include a ten-year transition for fixed capital on a straight-line basis. (These analyses are contained in the Technical Appendixes.)

The Commission also modified its recommendation for moveable capital to provide a three-year transition. Moveable capital typically has a shorter useful life than fixed, and therefore, is purchased and replaced more frequently. In addition, moveable capital expenditures require hospital managers to make judgments regarding capital/operating cost trade-offs.

Furthermore, based on information provided by the industry, the Commission concluded that a three-year transition would allow hospitals greater flexibility and reduced financial risk.

The Commission reaffirms its 1986 recommendation that during the transition period, hospital-specific payment should be based on actual capital costs adjusted for OBRA 1986 reduction. This will assist hospitals in meeting their debt obligations and encourage cost-effective capital decision-making in the future.

Institutional Neutrality

The Commission adopted a new recommendation in 1987 regarding what we call institutional neutrality. The Commission believes that supplemental payments should be made to hospitals for Medicare inpatients who receive services at other facilities. Currently, Medicare does not reimburse capital costs incurred by Medicare inpatients for services provided by facilities other than the hospital receiving the DRG payment. The supplemental payment would recognize the capital costs associated with those services. These supplemental payments would continue until the start of the transition to an all-inclusive PPS payment rate. Additional information on this recommendation is contained in the Technical Appendixes to the Commission's 1987 Report to the Secretary.

Capital Exceptions Process

In its 1986 Report the Commission indicated that it would continue to assess the impact of new capital payment policy on hospitals. As a result of further analysis, the Commission is recommending a capital exceptions process.

We believe that the prospective payment system for capital, which we have outlined, will be adequate for the vast majority of hospitals. However, some hospitals may inappropriately experience financial hardship as a result of a new capital payment policy. Therefore, the Commission recommends that the Secretary develop an exceptions policy to assist these hospitals. The criteria established to determine eligibility for an exception should emphasize the goal of ensuring Medicare beneficiary access to high-quality hospital services. This exceptions process should not be used to assist hospitals simply because they are in financial difficulty.

ProPAC sponsored the development of a capital investment model and conducted an analysis to estimate the impact of new capital payment policy on hospitals. Let me briefly describe this

analyses. A more detailed description of this analysis is included in the Technical Appendixes to the Commission's 1987 Report to the Secretary.

The first step in our analysis was to obtain information on hospital capital investment cycles. These cycles are based, in part, on Medicare's definition of capital costs, i.e. depreciation and interest. ProPAC contracted with the Johns Hopkins University Center for Hospital Finance and Management to examine hospital investment cycles. The analysis demonstrated that hospitals experience capital expenditures of a cyclical nature. It also indicated that a hospital's position in the investment cycle affects its capital-to-operating cost ratios and aggregate capital expenditures. Additional analyses showed that the planning phase of a capital project may last from one to three years and the actual construction phase may last from one to three years.

Using this information, ProPAC engaged Lewin and Associates, Inc. to develop an accounting model, which we call the ProPAC Investment Model, to assess financial outcomes for hypothetical hospitals under various capital payment proposals. The model examines vulnerability with respect to the hospital's position in the investment/renovation cycle; reliance on debt financing; dependency on Medicare revenues; capacity utilization; and overall financial viability. The ProPAC Investment Model also allowed for different assumptions about the level of capital payment and transition period to be tested.

Using the ProPAC Investment Model, the factors demonstrating the greatest effect on vulnerability are the hospital's position in the investment/renovation cycle, capacity utilization, and overall financial condition. Specific thresholds were selected that combine the effects of these three factors. Using first-year PPS Medicare cost report data, our staff examined the distribution of hospitals falling within the specific vulnerability thresholds.

Using the specific thresholds derived from the ProPAC Investment Model, ProPAC estimates that approximately 3.3 percent of hospitals are potentially vulnerable as a direct result of the inclusion of capital into PPS. Vulnerability did not vary significantly with traditional hospital classes, such as teaching or disproportionate share status, or urban or rural location.

I would like to stress that this analysis, based on hypothetical hospitals, was only designed to estimate the number and type of hospitals whose financial vulnerability results from the inclusion of capital into PPS. It was not designed to establish the specific eligibility criteria or the dollar amount necessary to fund an exceptions process. In addition, the analysis excluded hospitals that are financially vulnerable under PPS without the inclusion of capital.

Although this analysis indicates that some hospitals will be vulnerable to the inclusion of capital, the Commission believes that hospitals will not experience financial difficulty during the early years of our proposed transition. Therefore, the transition to an all-inclusive rate should begin in fiscal year 1988 and the exceptions process should be developed as soon as possible.

SUMMARY

In concluding, we believe that the recommendations we advanced last year, with the modifications we have suggested for this year, represent a desirable approach to bringing capital under PPS. It is our belief that by paying hospitals under a cost minus system they will be unfairly penalized for reducing their capital expenditures. We believe our approach will provide

hospitals with both the incentives necessary to control their capital costs and the opportunity to adjust their behavior.

We look forward to working with the Subcommittee and your staff on this important issue. Thank you for giving us an opportunity to testify today. Mr. Chairman, I would be happy to respond to any questions you or other members of the Subcommittee may have.

PROSPECTIVE PAYMENT
ASSESSMENT COMMISSION

REPORT AND RECOMMENDATIONS TO THE SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

APRIL 1, 1987

Capital

Recommendation 7: All-Inclusive Rate

The Secretary should initiate a transition to a new capital payment method beginning in fiscal year 1988. This method should combine operating and capital cost components in a single prospective payment per case.

This recommendation is a reaffirmation of a recommendation ProPAC made in its April 1986 report. The Commission continues to be convinced that retrospective cost-based reimbursement for capital introduces distorted incentives for investment decision making that need to be corrected as soon as possible.

The existing capital cost pass-through fails to encourage hospitals to evaluate interest rates or alternative financing methods in planning or investment decisions. This payment mechanism has led some hospitals to undertake capital expansion projects that may exceed the needs of the population served, thereby resulting in excess capacity. The capital cost pass-through provides incentives for hospitals to inappropriately substitute capital for labor or other operating costs.

The Commission believes that the Medicare capital payment system should provide hospital managers with flexibility to implement the most cost-effective decisions based on their institution's unique characteristics. While cost pass-through payment limits reduce Medicare outlays, this method still fails to provide hospitals with appropriate incentives to change their investment behavior. For this reason, the Commission recommends that an all-inclusive payment rate, combining operating and capital cost components in a single per-case payment, should be implemented beginning in Federal fiscal year 1988.

During the discussion of capital payment methods, the Commission considered arguments against recommending the all-inclusive rate approach. It was pointed out that this method of payment would represent an unprecedented departure from current reimbursement practices, which link payment amounts to hospital investment cycles. In addition, some Commissioners were concerned that a flat payment system would be insensitive to community need and therefore potentially wasteful. Despite these concerns, however, the Commission decided that the advantages of an all-inclusive rate outweigh the disadvantages.

Furthermore, the Commission continues to maintain that the capital payment method adopted should distinguish between fixed capital (buildings and fixed equipment) and moveable capital (moveable equipment). The method should recognize differences in the nature of fixed and moveable capital expenditures and the incentives influencing hospital decisions for these components.

Finally, the Commission is concerned about the effects of recent tax reform legislation (Pub. L. 99-514) on hospitals during the transition to prospective capital payments. This legislation contains a provision that limits the number of times a hospital can refund an existing tax-exempt bond issue. Limitations on the number of refundings may impair some hospitals' ability to reduce their capital-related costs. This impairment may, in turn, contribute to hospital financial vulnerability under new Medicare capital payment policy. The Commission will monitor the effects of this legislation as it considers alternative financing mechanisms available to reduce vulnerability for certain hospitals during the capital payment transition period. (For more information on tax reform changes, see Technical Appendix A.)

In its deliberations leading to the reaffirmation of the all-inclusive rate, the Commission considered grandfathering capital costs. The proposal was advanced by members of the hospital industry and is under consideration by the Congress. After reviewing the proposal, the Commission concluded that its phase-in approach is a more equitable and appropriate way to bring capital payment into PPS.

Based on analysis conducted by ProPAC staff, the Commission concluded that those hospitals that grandfathering was intended to protect (i.e., hospitals with recent major capital expenditures) are reasonably protected under a capital payment transition plan similar to that proposed by the Commission. Furthermore, the magnitude of individual hospital gains and losses relative to actual cash needs is far greater under grandfathering than under a more traditional capital payment approach as recommended by ProPAC. Finally, the grandfathering approach poses potential serious financial hardship for hospitals that need to build in the near future, yet miss the grandfathering deadline. Therefore, the Commission rejected the grandfathering approach and adopted the capital payment plan outlined in the following recommendations. (For a description of the analysis, see Technical Appendix A.)

Recommendation 8: Level of Federal Capital Payment

Capital payments should be added to the Federal portion of PPS payments for hospital cost reporting years beginning in fiscal year 1988 at a spending level consistent with that established by the Omnibus Budget Reconciliation Act of 1986.

The level for fiscal years 1988 and 1989 should be based on official Medicare inpatient capital spending projections in fiscal year 1987. The projections should include all capital components as presently determined on a reasonable cost basis.

The Omnibus Budget Reconciliation Act of 1986 requires the Secretary to reduce the amounts for capital-related payments to PPS hospitals (determined on a reasonable cost basis) by 3.5 percent, 7 percent, and 10 percent for portions of cost-reporting periods occurring in Federal fiscal years 1987 through 1989, respectively. OBRA 1986 recognizes that the Secretary has the authority to incorporate capital payments into the prospective payment system or to continue payments on a reasonable cost basis. However, the Secretary may choose to incorporate capital into PPS by regulations. If this occurs, Medicare aggregate payment amounts

for capital under the new system must be the same as they would have been if they were determined on a reasonable cost basis subject to the above reductions. Sole Community Hospitals are exempt from the reductions specified above. Furthermore, if the Secretary implements, by regulation, a new system for capital payment, Sole Community Hospitals would be exempt from the new system for the first three years.

The Commission recognizes that the Congress may limit capital payments in the future. In addition, the Secretary may constrain the increase in capital expenditures after Federal fiscal year 1989, when the reductions required by OBRA 1986 expire.

The Secretary should project actual inpatient capital spending levels under cost-based reimbursement for Federal fiscal years 1988 and 1989 based on the best data available in Federal fiscal year 1987. The spending reductions required under OBRA 1986 should be taken from these projections. The Commission believes that this approach would prevent hospitals from being penalized if they respond positively to the incentives of a new capital payment system.

Furthermore, the Commission believes that, in establishing the payment level for Federal fiscal years 1988 and 1989, the Secretary should not apply all the spending reductions required by OBRA 1986 to the Federal portion of the capital payment amount. Such reductions should not disproportionately affect one capital component more than another.

As hospital capital payments become more dependent on the Federal portion, financial problems could arise. The Commission believes that the hospital-specific and Federal payments, and the fixed and moveable portions of these payments, should be reduced equitably. This would provide appropriate incentives for hospitals to reduce overall capital spending levels, while affording them an opportunity to adjust their behavior. The Commission is concerned that the Secretary may apply all the spending reductions required by OBRA 1986 to the Federal portion of the capital payment amount. If this happens, the Federal portion could be severely constrained in the later years of the transition. This could lead to a Federal payment amount that is lower than may otherwise be desirable.

The Commission recognizes that in attempting to be in accordance with OBRA 1986 while moving toward a new method of capital payment, desired long-term savings may not be attained immediately. It is more important that hospitals be afforded a smooth transition and an opportunity to adjust their behavior without major financial disruption.

The Commission intends to closely monitor the appropriateness of the level of Federal capital payments during Federal fiscal years 1988 and 1989, and encourages the Secretary to do likewise. Information obtained during this period will help determine what capital payment limits, if any, should be imposed after Federal fiscal year 1989.

Recommendation 9: Capital Payment Transition

The transition to Federal capital payments under PPS should begin in fiscal year 1988 in the following manner.

- **Payments for fixed capital should be phased in over a ten-year period on a straight-line basis.**
- **Payments for moveable capital should be phased in over a three-year period on a straight-line basis.**
- **Hospital-specific fixed and moveable capital payment portions should be based on the actual capital costs incurred during each year of the transition.**

The Commission reiterates its belief that hospitals need a transition period to help them absorb the financial impact of a new Medicare capital payment system and to adjust their spending behavior accordingly. Further, the Commission believes that during this transition period hospital-specific payments should be based on actual capital costs. This will assist hospitals in meeting their debt obligations and encourage cost-effective capital decision making in the future.

The Commission continues to believe that the transition for fixed capital should be relatively long. The capital payment system should allow for the long-term nature of fixed capital expenditures and the need for hospitals to meet financial commitments obligated prior to the beginning of PPS.

In the April 1986 report to the Secretary, the Commission recommended a seven- to ten-year transition for fixed capital. Since that time, the Commission has conducted additional analyses comparing these two transition options. The Commission concluded that a ten-year transition provided more financial protection to a broader group of hospitals. Additional analysis indicated that a ten-year transition provided adequate protection from significant financial hardship. (See Technical Appendix A.) Hence, the Commission has revised its recommendation accordingly to include a ten-year transition for fixed capital. During the transition, the hospital-specific payment share would decline by approximately 10 percent a year, and the Federal payment share would increase by approximately 10 percent a year.

After considering information provided by representatives of the health care industry, the Commission also reexamined its position regarding a transition for moveable capital expenses. The Commission concluded that a transition for moveable capital would allow hospitals greater flexibility and reduced financial risk while moving to prospective payments for moveable capital.

Consequently, the Commission decided to incorporate a three-year transition for moveable capital into its capital payment recommendation. The hospital-specific payment share would decline by approximately 33 percent a year, and the Federal payment share would increase by approximately 33 percent a year.

The Commission reiterates its position that movement to an all-inclusive payment under PPS is its primary objective in developing a capital payment policy. The transition mechanism incorporated in such policy should ensure that most hospitals can meet their long-term capital commitments while providing incentives to make cost-effective capital decisions for the future.

Recommendation 10: Institutional Neutrality

Until the start of the transition to an all-inclusive PPS payment rate, the Secretary should provide supplemental payments to hospitals for capital costs incurred at other facilities. These costs are not currently reimbursed by Medicare.

Capital payment policy under PPS should allow for fair payment of capital-related expenses associated with providing services to Medicare patients, regardless of the site of care. Inpatients may receive services at a facility other than the hospital that receives the DRG payment. Currently, Medicare does not pay the capital-related costs of providing these services. Thus, hospitals have an incentive to provide all services in-house, even if this is not the most efficient use of resources.

When a hospital contracts with another facility to provide patient services, the hospital is billed by the other facility for operating and capital-related costs. However, the capital-related costs are not used in the calculation of the hospital's capital pass-through payment. (See Technical Appendix A.)

Supplemental payments for these capital costs should be made until the start of a transition to an all-inclusive payment rate. Under an all-inclusive rate, hospitals would receive a payment reflecting the total costs (i.e., both operating and capital costs) of all services provided, regardless of the delivery site. Hospital managers would have an incentive to select the most cost-effective method and site of treatment for Medicare inpatients.

The Secretary also should consider the extent to which this problem affects hospitals that are exempt from PPS. The payment incentives described previously also apply to exempt hospitals, because their operating costs are subject to the rate of increase limits.

Recommendation 11: Capital Exceptions Process

The Secretary should develop an exceptions policy to assist hospitals that are vulnerable to financial hardship when capital payment is included under PPS. Hospital eligibility criteria should emphasize the goal of ensuring continued access of Medicare beneficiaries to high-quality hospital services. The exceptions policy should not be used to protect hospitals simply because they are in financial difficulty. Therefore, a limited dollar pool should be made available with strict criteria to be used in determining which hospitals would be eligible for a capital payment adjustment.

The Commission believes that, while its proposed capital payment system is adequate for the vast majority of hospitals, some hospitals may experience financial hardship as a result of new policy. During the past year, ProPAC sponsored the development of a capital investment model and conducted analysis to estimate the magnitude and distribution of hospitals that are vulnerable as a direct result of new capital payment policy.

Analysis results indicate that few hospitals appear to be vulnerable as a result of the inclusion of capital into PPS. (See Technical Appendix A.) Furthermore, capital vulnerability appears to be evenly distributed across hospital classes as currently defined for Medicare payment purposes. Analysis results also indicate that ProPAC's capital payment plan provides appropriate incentives for hospitals to evaluate overall financial condition and capacity utilization and to adjust their capital spending behavior accordingly.

Nevertheless, the Commission is concerned that quality and accessibility of care for Medicare beneficiaries may be jeopardized by the vulnerability of some hospitals to financial hardship when capital payment is included under PPS. Therefore, the Commission recommends that an exceptions policy be adopted to address the financial needs of these institutions.

The transition to an all-inclusive rate, as the Commission has recommended, should not be contingent on the development of an exceptions policy. Most capital vulnerable hospitals would not experience financial shortfalls during the early years of the transition to ProPAC's capital payment system. The Commission believes that, during this period, capital payments are sufficient to meet the hospital's cash needs. Even so, the Secretary should develop an exceptions process as soon as possible. This process will enable hospitals to better plan future capital investments and assist those that will become capital vulnerable in later years.

The exceptions policy should not focus on a single class of hospitals. Instead, its should consider hospital financial condition and beneficiary access in determining eligibility and appropriate remedies. Furthermore, the exceptions process should be budget neutral, deriving funds from aggregate capital payments for hospitals.

The Commission will continue to study the issue of capital vulnerability in an effort to assist the Secretary in developing an exceptions policy. Efforts will focus on better understanding the nature, distribution, and factors influencing capital vulnerability. The Commission also plans to examine financing mechanisms that may assist capital-vulnerable hospitals during periods of financial difficulty.

Chairman STARK. Dr. Cohen, I have had some vague discontent with this 3-year, 10-year transition fixed and movable. Whose definitions of fixed and movable are hospitals going to use?

Mr. COHEN. Medicare's definition. Medicare has very specific definitions in its instructions for filling out the Medicare cost report, as to what is fixed and movable.

These definitions are based on the American Hospital Association Guide for Useful Lives which classifies assets as buildings, fixed equipment, and movable.

And the Medicare Provider Reimbursement Manual provides a description of which is which.

Chairman STARK. How would you describe that to a layman like me? What would you say buildings are?

Mr. COHEN. Buildings. Yes, buildings are fixed equipment.

Chairman STARK. What else is fixed?

Mr. COHEN. Things such as elevators. Parts of the building.

Chairman STARK. Parts of the building?

Dr. COHEN. Yes. In fact it has always struck me as entertaining that elevators are defined as fixed equipment when their purpose is to move, but that is correct.

Chairman STARK. So basically, or, in general, it is the buildings and the equipment—air conditioning, escalators, that sort of thing—it does not have anything to do with what we normally think of as depreciable lifetime in the Tax Code, for instance?

Mr. COHEN. Yes. The main movable equipment are the x ray machines, computers, and things of that sort.

Chairman STARK. What about furniture, and all that?

Mr. COHEN. That is all movable equipment.

Chairman STARK. All movable?

Mr. COHEN. Yes. Beds.

Chairman STARK. Where do you differ from the administration's proposal?

Mr. COHEN. Well, first of all we differ from the administration's proposal in that we would phase in fixed capital and equipment faster than they would. We use a 10-year straight-line transition—that is to say, 90, 80, 70, 60 percent—rather than their proposal which is 95, 90, 85, 80, and then near the end they speed things up.

Chairman STARK. So yours is pretty much straight-line, and theirs has more of a bulge in the curve in the early years?

Mr. COHEN. Yes. That is correct. We also recommend an exceptions process which they have not indicated whether they are going to recommend or not.

Chairman STARK. Now is that just for our guidance, or do you think there is a need for that? Do you see some cases——

Mr. COHEN. We believe that sometime down the line, that there will be need for an exceptions process to assist some hospitals.

Now, there are various ways to design an exceptions process. I also would note that ProPAC's position on an exceptions process is that it should not be a bailout situation; it should be very tightly defined, and not designed to bail out hospitals simply because they are in financial jeopardy.

But that there should be a system to respond to individual hospitals. And I might indicate my own personal feeling, that one possibility would be to allow hospitals to borrow forward on their future

Medicare payments, and another possibility is for you, Congress, to be very considerate of what you do through tax policy. A lot of the way hospitals will want to respond to the cash flow of a prospective payment system may be to redesign their cash flow obligations under their debt, and they may run into problems because tax law says they cannot redesign.

So I would ask you to be quite considerate about allowing them to respond to the incentives by perhaps considering that element of what you do.

Chairman STARK. Would you be better able to determine the need for an exceptions policy, and give us an idea of how extensive it might be if we had some kind of uniform reporting required of all hospitals in the country, similar to what they do in the State of California? Would that make your job easier in determining those?

Mr. COHEN. Well, I think, Mr. Chairman, that using the income statement information on the Medicare cost report, and using the charge information in the MEDPAR data set associated with the cost-to-charge ratios in the Medicare cost report, that ProPAC's staff has done a very commendable job which——

Chairman STARK. I would agree.

Mr. COHEN [continuing]. I feel quite comfortable with as far as the evaluation.

Chairman STARK. But it says nothing to the private income that they get, the same hospital——

Mr. COHEN. That is correct.

Chairman STARK. So you really are not looking at a whole hospital?

Mr. COHEN. That is correct. It is Medicare vulnerability, and not the whole hospital.

Chairman STARK. So you could have a hospital where you would say, goodness, this hospital looks like it is in trouble, when, really, they are cutting a fat hog on private patients and do not need any money at all?

Mr. COHEN. No, our study was simply based on Medicare income. We have not considered non-Medicare revenue. We have assumed that the PPS is to pay for Medicare patients, and we have not looked at what the impact is of what is happening for other patients.

Chairman STARK. Mr. Gradison.

Mr. GRADISON. Dr. Cohen, I have been leaning towards the idea that what we ought to do is just keep present law, and encourage the industry to spend another year or two to come up with some ideas, but as I have thought about it more recently, I am torn on this one and I would like your advice.

Everything that has happened in the last year or two suggests to me that giving another year or two is not going to solve anything. That the reason that we have not gotten industry consensus in the last year or two, is because any plan that anyone comes up with, from the industry or from anywhere else, is going to have winners and losers, and that industry groups cannot afford to alienate the losers, and so they ask for a little more time to study the problem.

Or to put it another way, I am skeptical that a year or two from now we are not going to know any more than we know today. That is the one pull.

The other pull is, well, if that is the case, if we are not going to know anymore, why not get on with it and just go with the plan. with the understanding that it may have some problems in practice, as the DRGs have had in practice, but that we are around all the time, and you are around and others are around to keep an eye on things and help us straighten them out if they do not turn out to work too well in practice.

So how would you advise somebody? I feel that is a genuine statement of my perplexity, sir.

Mr. COHEN. Mr. Gradison, I would advise you to begin. I feel very strongly, as does ProPAC, that it is the time to start paying hospitals on a prospective payment basis for capital.

I believe that in the first year especially, whether it is ProPAC's system where you pay 90 percent for fixed, or the administration's 95 percent on the hospital basis and the rest on the Federal basis there is no conceivable way that hospitals are going to run into particular problems. And yet you have started down what I believe is the right track with the right incentives.

I might indicate, as the chairman indicated, I have been administering for some 15 years the prospective payment system in Maryland. Maryland built capital into the system prospectively from day one. Movable equipment was done totally prospectively with no transition. Hospitals had no problem and responded dramatically to the incentives. Leasing went out, hospitals bought equipment but they financed it in ways that it didn't cost Medicare a lot of money. I mean there are a lot of incentives that are changed by the way you pay. And in fact that is one of the major reasons why ProPAC has suggested that in setting the level of Federal capital payment consistent with the OBRA 1986 limits, that is, in a budget neutral manner that you have to do it based on today's projections what payments would be under current law. That way, when the hospitals next year and the year after respond to the capital prospective payment system by maybe refinancing faster, by stopping leasing and doing things that cost less money, that they will get to keep that money as they should under prospective payment system. Rather than come back a year or two from now and say, hey, your costs were much lower than we thought they were going to be so we are only going to pay you 90 percent of what your new costs were that you reduced. That would be inappropriate. That is why ProPAC has recommended that the level be based on current projections, and then give the hospitals the savings that they generate by responding to the incentives, and their huge abilities to respond.

Mr. GRADISON. Thank you, Dr. Cohen.

Thank you, Mr. Chairman.

Chairman STARK. If the gentleman would yield.

In Maryland you had a reporting system, did you not?

Mr. COHEN. Yes. We have the uniform——

Chairman STARK. It was very helpful, wasn't it, to have the reporting system there?

Dr. COHEN. And it was very helpful in developing, for example, capital specific costs for different DRGs which we have done in Maryland as well.

Chairman STARK. Mr. Levin?

Mr. LEVIN. I have no questions.

Chairman STARK. Mr. Pickle?

Mr. PICKLE. Just an observation.

Your testimony seems to me much the same as the previous witness. I do not think there is anything too different in it, so I won't go over the same analysis.

It seems to me you are trying to stop ProPAC and make it more difficult to build hospitals, based on efforts to increase efficiency. You say this is a new and more efficient system. And you are creating it by just changing your formula.

It concerns me because I do not necessarily want to slow down the flow of capital. You are going to hurt rural areas. You are going to hurt some of the hospitals in my district that have already paid for their plans. It may be a little more efficient, but I think that hospitals are going to get hurt in the long run. So I just have the general feeling—I don't have any specific questions—but it seems to me like you are going to hurt the rural areas and hurt some of those hospitals just for the sake of slowing down the flow of capital.

Dr. COHEN. Mr. Chairman, if I may respond.

Two elements. First of all, we are not at all interested in stopping the flow of capital. What we are trying to do is give hospitals, as Mr. Anthony said, an appropriate economic incentive for the decision of whether they should spend the revenue you give them for providing care for Medicare patients on capital supplies or labor. We just want them to have economic incentives which are neutral as to which way they spend their money. And if they choose to spend their money, that's fine.

But that they won't have an incentive which distorts that decision.

As regard to the rural hospital question, we are fully aware, first, that by law the sole community hospitals are exempt for the first 3 years from any new capital payment system. But you should also be aware that ProPAC specifically has recommended this year that limiting the relief to rural hospitals to sole community hospitals, as opposed to the group of isolated community hospitals is inappropriate. And we have actually recommended that Congress not provide relief only to those isolated rural hospitals which choose to take advantage of the option to become sole community providers.

So we are quite concerned with that issue, and we have actually recommended easing up on who would be exempt actually.

Mr. PICKLE. Thank you, sir.

Chairman STARK. Thank you very much, Dr. Cohen. We appreciate your testimony.

Our next witness is Ms. Peggy Connerton, the chief economist for the Service Employees International Union.

Welcome to the committee, and you may proceed in any manner you are comfortable.

STATEMENT OF PEGGY CONNERTON, CHIEF ECONOMIST, SERVICE EMPLOYEES INTERNATIONAL UNION, AFL-CIO, CLC

Ms. CONNERTON. Thank you, Mr. Chairman.

I am Peggy Connerton, chief economist for the Service Employees International Union.

On behalf of our 850,000 members and our president, John J. Sweeney, I thank you for the opportunity to testify today on the need to bring capital costs under the prospective payment system.

SEIU is the largest health care union in the United States representing 275,000 workers. Our members know firsthand that hospital workers and patients today carry the full burden of cuts in health care spending. Meanwhile, hospitals remain free to bill Medicare for the entire cost of building projects, remodeling, and purchasing new equipment. We all know why this occurs.

It occurs because of the current bias against labor in the DRG system. SEIU supports legislation to immediately put an end to this anti-labor bias by bringing capital costs into the prospective payment system. In the long run, health care cost containment will require that we control all sources of cost.

On the subject of the bias against labor and in favor of capital under the current system, we see these perverse incentives played out in city after city. Hospitals impose wage freezes and lay off workers while adding more beds and purchasing more expensive services in an industry that is characterized by excess capacity and heavy duplication of services.

SEIU recently conducted a survey of our members on the impact of the DRG system. One of the questions that we asked was how DRG's had affected wages, working conditions and patient care. On the other side, we asked our members at our locals to tell us what kinds of purchases and building renovations had taken place. This is for the period 1984 to 1985.

The survey results best depict what is happening at a community hospital. The survey findings highlight the substitution of capital for labor. In hospital after hospital, staffing cutbacks stand side by side with new technology purchases and new construction.

For example, nearly 88 percent of the hospitals imposed hiring freezes on workers and 53 percent reported that there were actual layoffs at their hospitals. Those which gave the actual numbers had a layoff rate that was over 10 percent of the members of our bargaining unit.

Hospitals at this stage have gone well beyond "trimming the fat." Over 87 percent of our surveyed members report that their units are now operating dangerously short-staffed thanks to current DRG incentives.

At the same time, 75 percent reported their hospitals engaging in substantial new renovation and construction, and 55 percent of the hospitals purchased major new equipment.

In fact, hospital workers today say that their staffs have been cut so much that they cannot provide quality care. Understaffing is now common at every level of care.

In addition to patient care problems arising from insufficient nurses, we found that other support staff, like aides and orderlies who are responsible for turning, lifting, bathing and feeding patients, have been cut back to levels where patients are forced to wait substantial periods for attention, and where finally many patients are not getting the care they need.

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We have provided some examples in our testimony of instances where we found through our members that there has been insufficient attention to patients and quality care has diminished as a result of short staffing.

In short, the time has come to end this bias in the current DRG system by bringing all hospital expenses under control. As a first step, we would support legislation along the lines suggested by the Prospective Payment Assessment Commission. We support generally their recommendation, although we would like to see the phase-in period shortened somewhat, especially for movable equipment.

In general, the nation must focus its effort to contain health care costs on all sources of health care costs, the waste, the duplication of services, and ineffective care.

If we, instead, make it impossible for overworked, underpaid hospital staff to deliver compassionate health care, we all will suffer.

Health care without investment in people as well as investment in plant and equipment, is simply not care.

Thank you.

[The statement follows:]

TESTIMONY OF

THE SERVICE EMPLOYEES INTERNATIONAL UNION, AFL-CIO, CLC

ON

HOSPITAL CAPITAL EXPENDITURES

I AM PEGGY CONNERTON, CHIEF ECONOMIST OF THE SERVICE EMPLOYEES INTERNATIONAL UNION (SEIU). ON BEHALF OF OUR 850,000 MEMBERS AND OUR PRESIDENT JOHN J. SWEENEY, I THANK YOU FOR THE OPPORTUNITY TO COMMENT ON THE NEED TO BRING CAPITAL COSTS UNDER THE PROSPECTIVE PAYMENT SYSTEM.

I WANT TO START OUT BY SAYING THAT WE SUPPORT ALL RESPONSIBLE EFFORTS TO REFORM THE HEALTH CARE REIMBURSEMENT SYSTEM. OUR UNION IS DEEPLY CONCERNED WITH THE BATTLE TO CONTAIN THE RAPIDLY ESCALATING COST OF HEALTH CARE, BOTH AS CONSUMERS AND AS HEALTH CARE WORKERS.

SEIU IS THE LARGEST HEALTHCARE UNION IN THE UNITED STATES, REPRESENTING 275,000 WORKERS IN HOSPITALS AND NURSING HOMES. OUR MEMBERS KNOW-FIRST HAND THAT HOSPITAL WORKERS AND PATIENTS TODAY CARRY THE FULL BURDEN OF CUTS IN HEALTHCARE SPENDING. MEANWHILE, HOSPITALS REMAIN FREE TO BILL MEDICARE FOR THE ENTIRE COST OF BUILDING PROJECTS, REMODELING, AND NEW EQUIPMENT. DOCTORS, TOO, CAN CONTINUE TO CHARGE EXCESSIVE FEES.

THIS ANTI-LABOR BIAS OCCURS BECAUSE THE CURRENT DRG SYSTEM LIMITS MEDICARE PAYMENTS ONLY FOR OPERATING COSTS (LARGELY LABOR). AT THE SAME TIME, MEDICARE CONTINUES TO PAY ALL CAPITAL COSTS (DEPRECIATION, INTEREST, AND RENT) ON A PASS-THROUGH BASIS. THIS FEDERAL POLICY EFFECTIVELY TRANSFORMS LABOR COSTS INTO A DRAIN ON HOSPITAL BUDGETS, AND CAPITAL INTO A REVENUE PRODUCER AND GENERATOR OF FUNDS FOR EXPANSION. HOSPITALS ARE ENCOURAGED TO SUBSTITUTE CAPITAL FOR LABOR.

THESE ARE BIZARRE INCENTIVES IN A SYSTEM CRITICIZED FOR YEARS FOR EXCESSIVE SPENDING ON HOSPITAL FACILITIES AND EQUIPMENT, YET, RARELY, IF EVER, CRITICIZED FOR PROVIDING TOO MUCH PATIENT CARE, OVERLY NUTRITIOUS MEALS, OR AN EXCESS OF HOUSEKEEPING STAFF AND CLEANLINESS.

THE END OF CERTIFICATE OF NEED PROGRAMS AND HEALTH PLANNING IN MANY STATES IS FURTHER FUELING THE HEALTH CARE INDUSTRY'S CAPITAL SPENDING SPREE.

SEIU SUPPORTS LEGISLATION TO END THIS ANTI-LABOR BIAS BY BRINGING CAPITAL COSTS INTO THE PROSPECTIVE PAYMENT SYSTEM. IN THE LONG RUN, HEALTHCARE COST CONTAINMENT WILL REQUIRE THAT WE CONTROL ALL SOURCES OF COSTS.

CAPITAL-LABOR SUBSTITUTION

SEIU LOCALS ARE SEEING THESE PERVERSE INCENTIVES PLAYED OUT IN CITY AFTER CITY. HOSPITALS IMPOSE WAGE FREEZES AND LAY OFF WORKERS, WHILE EXPANDING AND ADDING MORE EXPENSIVE SERVICES -- WITH LITTLE ATTENTION TO WHETHER THE EQUIPMENT WILL DUPLICATE A NEIGHBORING HOSPITAL'S FACILITIES.

FOR EXAMPLE, SEIU LOCAL 627 IN YOUNGSTOWN, OHIO FACED AN ARRAY OF LABOR CUTBACKS AT 3 NON-PROFIT HOSPITALS -- INCLUDING 250 LAYOFFS, FREQUENT DOUBLE SHIFTS FOR LPNS AND NURSE AIDES, AND WAGE CONCESSIONS. DURING THIS SAME PERIOD, THE HOSPITALS SPENT $16 MILLION FOR AMONG OTHER THINGS, CAT SCANS, NEW OUTPATIENT SURGERY DIVISIONS AND EXTENSIVE BUILDING RENOVATION.

WORKERS TELL THE SAME STORY AT SERRA MEMORIAL HOSPITAL IN SUN VALLEY, CALIFORNIA. THE WORKERS ALSO FACED LAYOFFS AND HIRING FREEZES, WHILE THE HOSPITAL BUILT A NEW LOBBY, A LIBRARY, A DOCTORS' LOUNGE AND AN ER LOUNGE.

SEIU DRG SURVEY

WE CAN GENERALIZE THESE EXAMPLES, BASED ON A SURVEY RECENTLY MAILED TO SEIU'S 80 LOCALS REPRESENTING HOSPITAL WORKERS. THE SURVEY ASKS LOCALS TO TELL HOW DRGS AFFECTED WAGES, WORKING CONDITIONS, SERVICES AND PATIENT CARE.

WITH A RETURN RATE OF 25% OF OUR LOCALS COVERING ROUGHLY 30,000 SEIU HOSPITAL WORKERS, THE SURVEY RESULTS BEST DEPICT WHAT IS HAPPENING AT A "TYPICAL" COMMUNITY HOSPITAL. (TABLE 1 SHOWS THE AVERAGE BEDSIZE, OCCUPANCY RATES, AND FINANCES OF THE HOSPITALS IN OUR SURVEY WHICH MATCH CLOSELY THE AVERAGE INDUSTRY PROFILE FOR COMMUNITY HOSPITALS.)

THE SURVEY FINDINGS HIGHLIGHT THE SUBSTITUTION OF CAPITAL FOR LABOR. IN HOSPITAL AFTER HOSPITAL, STAFFING CUTBACKS STAND SIDE-BY-SIDE WITH NEW TECHNOLOGY PURCHASES AND NEW CONSTRUCTION. (SEE TABLE 2 FOR DETAILED RESULTS OF THE SURVEY.)

FOR EXAMPLE, NEARLY 88% OF THE HOSPITALS IMPOSED HIRING FREEZES ON WORKERS, AND 53% REPORTED THAT THERE WERE ACTUAL LAYOFFS AT THEIR HOSPITAL. OVER 60% OF THESE GAVE PRECISE FIGURES ON HOW MANY NURSES, CLERICAL WORKERS, TECHNICIANS, AIDES, ORDERLIES AND MAINTENANCE WORKERS HAVE BEEN LAID OFF AS WELL AS THE NUMBER OF POSITIONS LOST THROUGH ATTRITION.

FOR THOSE REPORTING EXACT FIGURES, THE LAYOFFS ON AVERAGE WIPED OUT OVER 10% OF THE WORKERS IN OUR BARGAINING UNITS.

HOSPITALS HAVE GONE WELL BEYOND "TRIMMING THE FAT". OVER 87% OF OUR SURVEYED MEMBERS REPORT THAT THEIR UNITS ARE NOW OPERATING DANGEROUSLY SHORT-STAFFED THANKS TO CURRENT DRG INCENTIVES.

AT THE SAME TIME, 75% REPORTED THEIR HOSPITALS ENGAGING IN SUBSTANTIAL NEW RENOVATION AND CONSTRUCTION AND 55% OF THE HOSPITALS PURCHASED MAJOR NEW EQUIPMENT.

WE'RE NOT SAYING THAT ALL THIS CAPITAL INVESTMENT IS UNNECESSARY. SOME OF OUR INNER CITY HOSPITALS HAVE BADLY OUTDATED PLANT AND EQUIPMENT. HOWEVER, IT'S HARD TO COMPREHEND ALL THIS BUILDING IN AN INDUSTRY SADDLED WITH EXCESS CAPACITY AND DUPLICATIVE TECHNOLOGY. BECAUSE CAPITAL COSTS CONTINUE TO BE EXCLUDED FROM PROSPECTIVE PAYMENTS, THE SYSTEM PROVIDES STRONG INCENTIVES FOR HOSPITALS TO OVERINVEST IN CAPITAL AT THE EXPENSE OF WORKERS.

LABOR NOT DRIVING HOSPITAL INFLATION

SINCE 1983, HOSPITALS HAVE LAID OFF 140,000 WORKERS NATIONWIDE. THIS SACRIFICE OF WORKERS COMES IN SPITE OF AMPLE EVIDENCE THAT LABOR COSTS DO NOT ACCOUNT FOR RUN AWAY HEALTH COSTS.

HOSPITAL WORKERS' WAGES, ADJUSTED FOR INFLATION, ARE BARELY ABOVE 1972 LEVELS.

IN FACT, LABOR COSTS HAVE TAKEN A SMALLER AND SMALLER BITE OUT OF TOTAL HOSPITAL BUDGETS. FROM 1965 TO 1985, PAYROLL COSTS DECLINED FROM 62% OF TOTAL EXPENDITURES TO 46%. THIS DRAMATIC REDUCTION OCCURRED DESPITE A 55% EXPANSION IN THE NUMBER OF EMPLOYEES PER PATIENT DUE TO FACTORS SUCH AS TECHNOLOGICAL ADVANCES, A SICKER PATIENT MIX AND SHORTER HOSPITAL STAYS -- ALL REQUIRING MORE INTENSE LEVELS OF SERVICE.

MOREOVER, THESE ARE TOTAL PAYROLL COSTS -- INCLUDING SUPERVISORY, PHYSICIANS, DENTISTS, RESIDENTS AND INTERNS SALARIES. ROUGH ADJUSTMENTS PUT NONSUPERVISORY COSTS AT LESS THAN 40% OF

TOTAL COSTS. THIS MEANS THAT A 10% INCREASE IN THE WAGES OF NONSUPERVISORY WORKERS WOULD PRODUCE LESS THAN A 4% INCREASE IN THE COSTS PER PATIENT DAY, GIVEN THE SAME LEVEL OF SERVICES.

WHILE LABOR COSTS HAVE DECLINED, CAPITAL COSTS ARE UP. THE NATIONAL STATISTICS CONFIRM THAT THE GROWTH RATE OF CAPITAL COSTS CONTINUES TO OUTSTRIP THE INCREASE IN TOTAL COSTS -- DESPITE THE LOW INTEREST RATES THE LAST 2 YEARS. CAPITAL COSTS IN 1986 INCREASED A WHOPPING 10.8%.

SHORT STAFFING AFFECTS PATIENTS' CARE

HOSPITAL WORKERS SAY THEIR STAFF HAVE BEEN CUT SO MUCH THAT THEY CANNOT PROVIDE QUALITY CARE. UNDERSTAFFING IS NOW COMMON AT EVERY LEVEL OF CARE. SINCE THE ADVENT OF DRGS NURSING STAFF REPORT:

- LOWER STAFF TO PATIENT RATIOS WHICH IN MANY UNITS NURSES FEEL ARE AT DANGEROUS LEVELS. FOR EXAMPLE, 3 LPNS WERE RESPONSIBLE FOR A 44 PATIENT SURGICAL UNIT IN ONE FACILITY.

- INCIDENT REPORTS COMPLETED DAILY BY ALL NURSES ARE MORE LIKELY TO CITE PROBLEMS ATTRIBUTED TO POOR STAFFING.

- WHEN STAFFING CRISES HIT, HOSPITALS ARE APT TO USE TEMPS AND FLOAT POOLS. AS A RESULT, NURSES FEEL THAT INADEQUATELY TRAINED PEOPLE ARE PLACED IN CRITICAL CARE AREAS AND ON OTHER UNITS WHERE SPECIALTY TRAINING IS NEEDED.

- PATIENT CARE STAFF ARE WORKING EXTENDED SHIFTS -- 12 AND 16 HOURS A DAY.

ALTHOUGH NURSING STAFF KNOW INTIMATELY THE IMPACT ON PATIENT CARE, ALL STAFF LEVELS HAVE BEEN AFFECTED BY CUTS.

OUR SURVEY SHOWS THAT THE NUMBER OF OTHER SUPPORT STAFF -- PARTICULARLY THE AIDES AND ORDERLIES WHO ARE RESPONSIBLE FOR TURNING, LIFTING, BATHING AND FEEDING PATIENTS -- HAVE BEEN CUTBACK TO LEVELS WHERE PATIENTS ARE FORCED TO WAIT LONGER FOR STAFF ATTENTION, WHERE THE AMBULATORY PATIENTS MUST OFTEN FEND FOR THEMSELVES, AND WHEN, FINALLY, MANY PATIENTS ARE NOT GETTING THE CARE THEY NEED.

CUTBACKS IN HOUSEKEEPING AND MAINTENANCE MEANS THAT LINEN AND SUPPLIES ARE OFTEN NOT AVAILABLE WHEN AND WHERE THEY ARE NEEDED. HOSPITAL CLEANLINESS HAS ALSO SUFFERED. OUR HOUSEKEEPING WORKERS REPORT THAT SINCE DRGS WERE IMPOSED THEY MUST CLEAN MORE SQUARE FEET OF SPACE PER DAY AND HAVE BEEN INSTRUCTED TO CLEAN SOME AREAS LESS FREQUENTLY.

FOR EXAMPLE, AT MCKEESPORT HOSPITAL IN PENNSYLVANIA, THE NURSING STAFF HAS SHRUNK FROM 450 NON-SUPERVISORY POSITIONS TO 386 SINCE DRGS STARTED. NURSES ARE SO BUSY THANKS TO HIGHER PATIENT TO STAFF RATIOS THAT PATIENTS ARE NOT GETTING CHANGED AND CALL-BUTTONS GO UNANSWERED.

AT YOUNGSTOWN HOSPITAL, WORKERS REPORT NUMEROUS INCIDENTS OF THEIR INABILITY TO PROVIDE ADEQUATE LEVELS OF CARE TO PATIENTS DUE TO UNDERSTAFFING. IN ONE CASE, AIDES WERE SO OVER WORKED THAT A PATIENT WHO HAD AN IV IN ONE ARM WAS GIVEN A WASH CLOTH AND ASKED TO BATHE HIMSELF. ANOTHER CASE FOUND A KIDNEY DIALYSIS PATIENT WITH VISION COMPLICATIONS NOT PROVIDED WITH AIDES TO HELP WITH MEALS. FURTHERMORE, THIS INDIVIDUAL WAS LEFT ON SEVERAL OCCASIONS TO ADMINISTER HER OWN EYE MEDICATION.

AT THE SERRA MEMORIAL HOSPITAL IN CALIFORNIA, UNDERSTAFFING IS A PARTICULARLY SEVERE PROBLEM IN CRITICAL CARE UNITS WITH SEVERAL VIOLATIONS NOTED BY INSPECTORS.

CONCLUSION

IN SHORT, THE TIME HAS COME TO END THE ANTI-LABOR BIAS IN THE CURRENT DRG SYSTEM BY BRINGING ALL HOSPITAL EXPENSES UNDER CONTROL. AS A FIRST STEP, WE WOULD SUPPORT LEGISLATION ALONG THE LINES SUGGESTED BY THE PROSPECTIVE PAYMENT ASSESSMENT COMMISSION. THEY RECOMMEND PHASING-IN CAPITAL AND OPERATING COSTS INTO A SINGLE ALL-INCLUSIVE PROSPECTIVE PAYMENT PER CASE. HOWEVER, WE WOULD LIKE TO SEE THE PHASE-IN PERIOD SHORTENED SOMEWHAT.

IN GENERAL, THE NATION MUST FOCUS ITS EFFORTS TO CONTAIN HEALTH CARE COSTS RESULTING FROM WASTE, DUPLICATION OF SERVICES AND INEFFECTIVE CARE. IF WE, INSTEAD, MAKE IT IMPOSSIBLE FOR OVER-WORKED, UNDERPAID HOSPITAL STAFF TO DELIVER COMPASSIONATE HEALTH CARE, WE ALL WILL SUFFER.

HEALTH CARE WITHOUT INVESTMENT IN PEOPLE IS SIMPLY NOT CARE.

THANK YOU.

TABLE 1. DRG SURVEY - SAMPLE CHARACTERISTICS

FACTS ON STAFF REDUCTIONS

	Average	Range
LAY-OFF RATE	10.5% *	2.5% - 35.8%
ATTRITION RATE	6.6% *	3.3% - 11.1%

* Represents percent reduction in bargaining unit staff.

Source: S.E.I.U. Survey - "The Impact of Diagnostic-Related Groups on Hospital Workers and Patients".

PROFILE OF HOSPITALS SURVEYED

	Average	Range
OCCUPANCY RATE	64.4%	33.3% - 82.1%
BED SIZE	255	63 - 1240
PROFIT RATE (Total net margin)	5.87%	.92% - 13.2%

Source: "Economic Trends", American Hospital Association, (December, 1985).

TABLE 2. DRG'S RAISE HOSPITALS' CAPITAL SPENDING AT EXPENSE OF HOSPITAL WORKERS

Staff Reductions	No. of Hospitals	Percent of Total Hospitals
Chronic Staffing Shortages	35	87.5 %
Hiring Freezes/Attrition	35	87.5 %
Not Replacing Absent/On Leave Workers	27	67.5 %
Increased Floating Assignments/Temporary Personnel/Contracting Out	26	65.0 %
Increased Part-time Work/Job Sharing	23	57.5 %
Lay-offs	21	52.5 %

Capital Investments	No. of Hospitals	Percent of Total Hospitals
Major Renovation/New Construction	30	75.0 %
Major Purchases of New Equipment (i.e. CAT/nuclear scanners)	22	55.0 %

Source: Service Employees International Union Special Survey- "The Impact of Diagnosis-Related Groups (DRG's) on Hospital Workers and Patients".

Chairman STARK. Thank you.

Do you have some more examples of which machine replaces which labor, or could you provide that? I would assume that that was an alternative, but I don't quite see a robot sticking a needle in my arm or bathing me.

Ms. CONNERTON. Well, believe it or not, they are working on an automated bedmaking system.

Chairman STARK. That is all right with me. I never liked making my own bed.

Are they going to import them from Japan? [Laughter.]

Ms. CONNERTON. I don't know.

Chairman STARK. Seriously, are there—I know in theory that is always the tradeoff, but in all seriousness, are there examples of where the——

Ms. CONNERTON. We can provide you with some examples.

Chairman STARK. I guess I could think of it in terms of nurses where you have got a monitoring system hooked up to a central monitoring station rather than having a nurse checking on a variety of patients.

Ms. CONNERTON. Right. Well, you also find that in the laboratories where there has been a lot of labor saving technology, for example, multiple analysis machines. There are other examples.

Chairman STARK. Have you done any work on the idea that new building design can make it more efficient? For example, a hub with wings extended out, one nurse can watch down three quarters instead of two.

Ms. CONNERTON. We have this kind of anecdotal evidence which we can supply this Committee.

Chairman STARK. Now, do you have any evidence—I'll ask this before one of my colleagues does—do you have any evidence where the union is being so unreasonable as to raise the wages in a community so high that you force the hospital to turn their backs on these hard working, underpaid members of your union and build new buildings, buy new equipment?

Ms. CONNERTON. I think that——

Chairman STARK. I know that doesn't happen in my district, but I just wondered if it might have happened elsewhere.

Ms. CONNERTON. It doesn't happen in your district definitely. But I would say that the answer is that wage costs as a proportion of total costs have really declined substantially in recent years. Labor is not a big contributor to hospital costs these days.

Chairman STARK. And I guess there really is no measure to the value of just having a human being dealing with you when you are ill as opposed to a machine. That is pretty difficult to measure.

Ms. CONNERTON. Right.

Chairman STARK. You haven't got a way to measure that yet?

Ms. CONNERTON. I haven't been able to quantify that, no.

Chairman STARK. Okay.

Mr. Levin.

Mr. LEVIN. Let me, if I might be clear, on page—oh, it's a few pages back where you say since 1983 hospitals have laid off 140,000 workers nationwide.

I am just curious. That is a striking figure. Does that mean there are 140,000 fewer workers? I take it you don't mean that. Were some of these people recalled, or what does that figure mean?

Ms. CONNERTON. Well, some of the people were converted to part-time temporary work. A large portion of hospitals converted full-time employment to more part-time staff during this, and that is what that measure reflects in part. And this is in an industry, by the way, which had been one of the fastest growing sources of employment until the mid eighties.

Mr. LEVIN. So the number of hospital workers would have increased overall?

Ms. CONNERTON. Right. Well, that was the past trend prior to the implementation of the DRG system. I mean it is an industry that, as you know, is very recession-proof. So the trend has been definitely one of steady growth.

Mr. LEVIN. Well, okay. I think, Mr. Chairman, the testimony is interesting and I would hope that maybe those who follow my comment on this argument that the system is presently slanted towards capital rather than labor intensity. That's the gist of it. It is not neutral in that sense, but it is crafted so that it leans distinctly toward the capital side rather than labor investment, people investment.

All right. Well, I kind of scanned the testimony that is coming. I am not sure if it covers this argument as well as some of the prior ones, but I hope we might be able to cover that in some of the questions.

Thank you.

Chairman STARK. Thank you very much, Ms. Connerton.

Our next witness is Mr. Elrod, Jr., a senior vice president of Dillon, Read.

Welcome to the committee, Mr. Elrod. We are going to ask you if you would like to summarize your statement or expand on it. Your full testimony will appear in the record in its entirety. Proceed in any manner you are comfortable.

STATEMENT OF JAMES L. ELROD, JR., SENIOR VICE PRESIDENT, DILLON, READ & CO., INC.

Mr. ELROD. Thank you, Mr. Chairman. What I would like to do is summarize the written testimony briefly, if I could, and then add a couple of other items that I hope are going to be helpful to your discussions.

Briefly put, the credit deterioration that this industry has seen is a byproduct of the DRG system. That is not really a subject that reasonable people can debate; it is a matter of record. I think incorporating capital into the DRG program is going to accelerate that trend for three reasons: Unlike operating expenses, you cannot really manage your way around capital commitments, particularly if you have just undertaken those commitments and they are extensive.

Second of all, as the prior witness indicated, there is going to be an almost frantic search for funds to withstand the shortfall, and that is going to put additional pressure on noncapital costs. There

is some skepticism in the market whether there is any excess left here.

Finally, in terms of the longer run, you are going to compromise the system by creating significant disincentives toward maintaining your asset base. What I would envision here is the potential for a fairly vicious cycle which starts with eroding investor confidence, which we have already seen. That translates into a reluctance to participate. Those that will participate are going to require a risk premium, and under the capitated system that is proposed, that increases your fixed costs and so we erode further investor confidence.

The result is not immediate, but it is going to be inevitable; that is, you are going to disenfranchise certain borrowers from the capital markets, and I would submit to you that many of the victims that would be disenfranchised are just those institutions that serve a high proportion of Medicare beneficiaries.

That is a summary of my written testimony. What I would like to get to today really are two points: First of all, to urge you to incorporate this whole notion of access to capital in your deliberations; and second of all, if you do that, please make sure or do your best to try and use the information that the market deems most relevant. I say that because there seems to be confusion abounding over the question of profitability versus cash flow. And over the last two years, there is some information that has been put in the marketplace about hospitals being wildly profitable, and that is a justification for somehow incorporating capital into the DRG program in and of itself.

I am afraid I am a little confused as to the logic of that, but I think it turns on some notion of affordability. I would submit to you that the capital markets are like any good long-term investor in that they care a lot more about the predictability of cash flow than they do about reported profits.

To illustrate that, I would like to briefly ask you to recall your first application for a home mortgage, if you made one. I have never seen an application that asked you what the difference was between your revenues and your expenses last year. I think lenders are interested, but I think they are more interested in the likelihood of timely payment over the long run.

So you see the typical questions asked are your length of employment——

Chairman STARK. Excuse me. Did you just say that in a home mortgage the lendee does not inquire as to the difference between your revenues and expenses for the last year?

Mr. ELROD. Over the last year. I do not think I have seen that line item.

Chairman STARK. I probably, by the time I was your age, had originated $800 or $900 million in mortgages, which I was happily servicing, and I would submit that that was one of the most extensive parts of our underwriting, as it is for FHA and GI loans: that the credit underwriting is perhaps more severe and more complex than purely the appraisal of the real property, and that, indeed, it is, as I remember from my Horne book credit analysis, that that is the sine qua non of mortgage lending.

Mr. ELROD. My experience is significantly less significant, but in my experience they care at least as much, Mr. Chairman, on the history of your compensation and your promotions, your net worth—which, of course, addresses how much you have been able to save over time—and, more importantly, the monthly cash flow as opposed to what you did last year.

What I would submit to you further is the key to lending for long-term mortgages is that it is predictability of cash flow more than your past profit during the last year. And so the capital markets ask for the same thing. They care about the predictability of cash flow more than they do about profit.

This industry has been punished somewhat by the DRG system in terms of its operating costs, and at least that has challenged the prior assumptions about the predictability of that cash flow. So given that experience, I would suggest that incorporating capital into the PPS system may create three problems for you:

First of all, there is the obvious problem of a cash flow crisis for institutions, specific institutions. Capital projects that have been entered into over the last 3 years are going to be a real problem, and you are going to, I think, come into some default situations which, by definition, are going to alienate those lenders, reducing the universe of buyers, and, again, raising the risk premium that we talked about earlier.

Second of all, I think the potential investor is going to be somewhat worried about the indifference toward existing commitments that the system is displaying. I agree with you; a 10-year phase-in is much preferable to a 4-year, but we are talking about timing rather than making the system whole.

And also you have to remember that investors have many choices today. The returns in this business have not been spectacular. I would recommend that you read the January 2, 1987, Wall Street Journal article which cites hospital management companies as the worst performers except for oil services and steel industry over the last year.

What you are going to find is some potential lenders will like not to engage in an industry where a critical partner is choosing to ignore the impact of existing contractual obligations. That is going to again reduce your buyer universe and raise the risk premium.

Finally, I would ask that you direct your attention to the not-for-profit industry specifically. Again, they account for 85 percent of the acute care beds in this country. In 1983, it is true, you told them that you were going to institute a system where the potential to earn profit was going to be equal to the potential to sustain a loss. And you did also tell them that you were going to change the system for reimbursing capital.

I think any good management at that time and any board member that was awake was going to say not just from an opportunity point of view, but from a point of view of survival, "We had better start saving now for the rainy day." Because the not-for-profits can only pass funds through their income statement to their balance sheet—they cannot go out and issue equity—they turned on the jets and they attempted to generate as much profit as was possible.

The analogy, that I give you is that an individual looking toward mandatory retirement in the last few years tries to save up for that rainy day as well. But the problem is, in being responsive to the system and responsible to those individual communities, now we are talking about their increase in profits on an operating basis as a reason or in part the basis for restricting the capital side. I am not talking about fairness here. That is for you folks to decide, but I would say that investors may not be attracted to an industry where evidence of good management is being used systematically to depress the potential for total returns over the long run.

So, in conclusion, I would urge you to consider this whole notion of access to capital. If you do that, I would urge you to listen to what the markets are telling you; that is, that they are not impressed with current levels of profitability, but that they are very concerned about the impact the DRGs, at least DRGs for capital, may have on the predictability of cash flow.

I would be happy to answer any questions.

[The statement of Mr. Elrod follows:]

STATEMENT OF JAMES L. ELROD, JR., SENIOR VICE PRESIDENT, DILLON, READ & CO. INC.

Mr. Chairman and Members of the Subcommittee, I appreciate this opportunity to express my views on the reaction the financial community may have to utilizing the DRG system for capital reimbursement. This system will raise the cost of capital for the entire industry. Access to the capital markets for a number of industry participants will be curtailed and, in some cases, eliminated. In sum, the reaction by the financial community will be negative.

The health care industry's credit position has deteriorated since DRG reimbursement for operating expenses was introduced. Three of the four largest investor-owned hospital companies have had their senior debt obligations downgraded by Standard & Poor's Corporation since 1983. These companies control approximately 73,000 beds or 60 percent of all proprietary hospital beds. Relative to their pre-DRG position, the cost of raising debt capital has increased for these companies.

Equally revealing is the performance of the common stock of each of these companies during this time. The common stock of the four major investor-owned hospital companies has lagged the market by a significant margin. This is particularly noteworthy given the unprecedented performance of the market in general since 1983. Relative to other sellers of equity, the cost of issuing equity capital has increased for these companies.

The signs of credit deterioration are more pronounced for nonprofit hospitals. Relying again on information obtained from Standard & Poor's, many more hospitals have had their bond ratings downgraded than upgraded since 1983. In fact, downgradings outpaced upgradings by a ratio of 17.5 to 1 in 1986. Institutions experiencing a downgrading must pay more for their borrowed funds, which raises their capital costs.

Credit deterioration was contained, in my opinion, because investors believed that good hospital management had the tools necessary to survive. That argument does not apply to capital costs because there is very little that can be done immediately about existing capital commitments. For example, the terms of debt borrowing are set in advance, and may be unalterable for many years. Nonprofit hospitals, which control approximately 85 percent of inpatient beds, are particularly ill-equipped to deal with this issue. Nonprofits have no source other than debt for meaningful amounts of external capital, and the significant restrictions on advance refundings imposed by the Tax Reform Act of 1986 strips them of their previous ability to deal with existing capital costs.

If capital costs are not fully reimbursed, and quality is to be maintained, non-capital costs must be lowered to make up any shortfall. This may be difficult to accomplish because the DRG system has already created incentives to cut costs. Additional operating economies may simply not exist. Also, hospital occupancy is now estimated to be 60 percent nationwide. The national decline in inpatient utilization (a goal of the DRG system) means that the base of patients over which operating economies can be realized is shrinking.

Assuming for the moment that any revenue losses can be supplemented from operations in the near term, concerns will be raised about the incentives such a system creates for hospital management. If profits are generated from operations, they ought to be reinvested in nonregulated, non-health care businesses where returns are not artifically depressed. "Good" management will not replace a depreciating asset base in a business where adequate returns are forbidden, perhaps compromising the longer term financial viability of the institution.

Investment considerations aside, the proposed system could have a significant impact on social and fiscal policy. The distribution of health services will, over time, become skewed toward profitable services. Access to a full range of services, particularly in rural areas, may be curtailed.

Research has indicated that financial distress is generally attributable to location rather than poor management or lack of demand. Many of the most socially desirable healthcare institutions—particularly large, urban hospitals—are already in financial distress because of their location and are poorly positioned to respond to a fixed capital add-on. I believe the most likely losers under the proposed system are those hospitals located in poor, already underserved communities.

The most likely winners are wealthy suburban institutions in growing markets with significant reserves. If this turns out to be the case, then access to quality healthcare will be denied in disproportionate numbers to Medicare beneficiaries.

Hospital managers will have no choice but to cost shift and move patients into higher reimbursement classifications (DRG "creep"). This has obvious negative financial implications for Medicare. Similarly, a flat add-on tied to operating expenses encourages growth in operating expenses and, whenever possible, excessive admissions.

Some hospitals also may conclude that while their credit position has deteriorated, things will get worse, and they should engage in any capital market transactions as soon as possible. This was the case in 1985 when the impending tax reform encouraged pre-funding of future projects for nonprofit hospitals and produced an unprecedented number of tax-exempt hospital bond offerings. Significant market activity could add pressure to interest rates, affecting other borrowers.

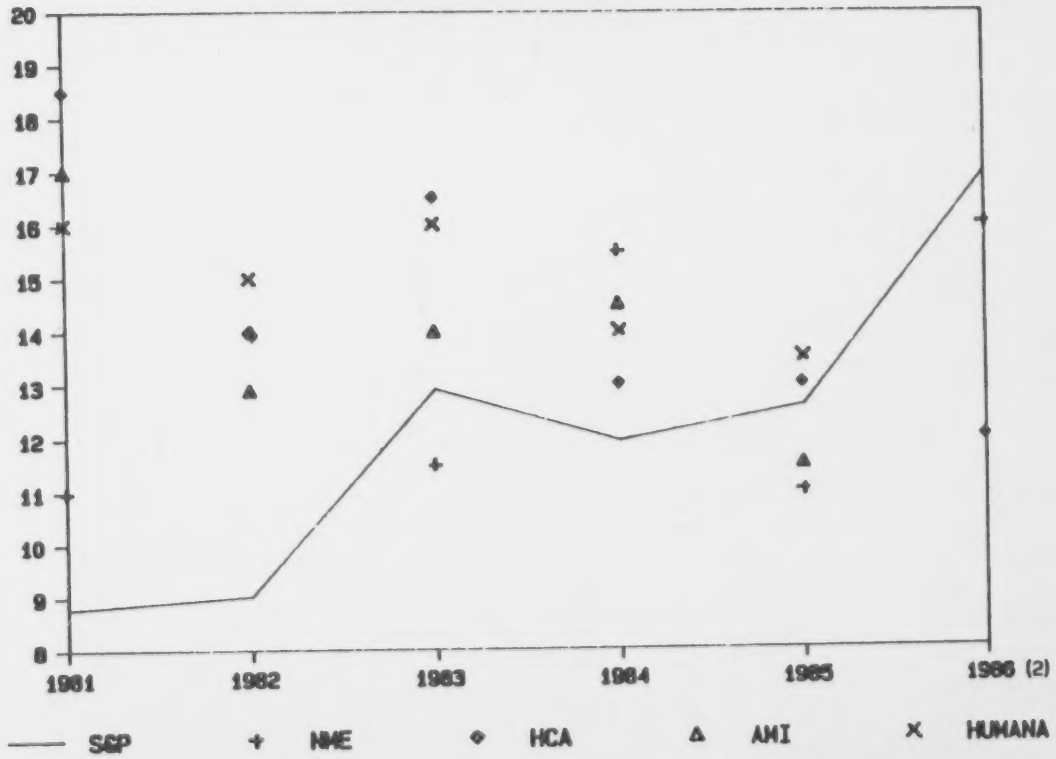
Taken together, these events will reduce investor demand for the securities of health care institutions. Reduced demand in the face of constant supply will raise capital costs, further compromising the financial position of issuing hospitals. In some cases, borrowers could be denied access to capital at any price. I am not suggesting that an immediate, wholesale alienation of the entire industry from the capital markets will take place. It will not. But I do envision a more limited access to capital on reasonable terms for a significant number of institutions.

In summary, prospective payment for operating costs has already led to the deterioration of the credit profile of the health care industry. Prospective payment of capital would heighten investor apprehension because of its short-term threat to financial stability and a concern that, unlike operating expenses, existing capital commitments cannot be "managed". These developments have broader policy implications, most of which are negative. I therefore believe that a DRG based system for capital will be viewed unfavorably by the investment community.

Standard & Poor's Proprietary
Hospital Senior Debt Rating Revisions
1983-Present

Company	1983 Debt Rating	Current Debt Rating
American Medical International, Inc.	A	BBB+
Hospital Corporation of America	A+	A
Humana, Inc.	A	A
National Medical Enterprises, Inc.	A-	BBB+

P/E Ratio Comparisons



Sources: (a) Standard NYSE Stock Reports
(b) SGP's Statistical Service

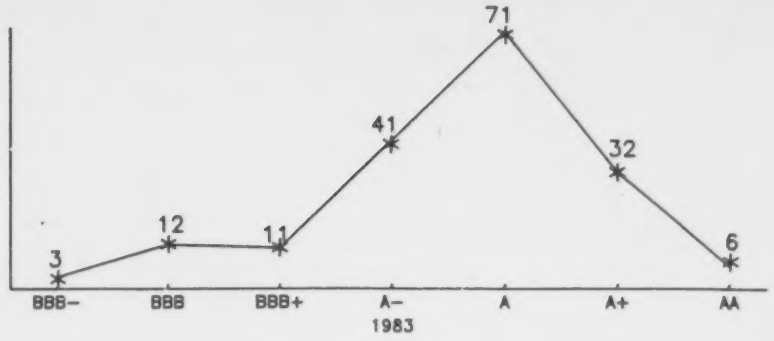
Notes: (1) Data points are averages of each year's high and low P/E ratios.
(2) 1986 data for AMI and Humana is not meaningful.

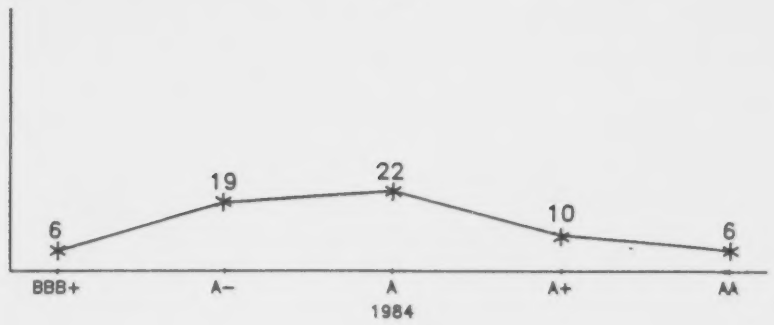
Standard & Poor's Tax Exempt Hospital Bond
Rating Revisions, 1983-1986

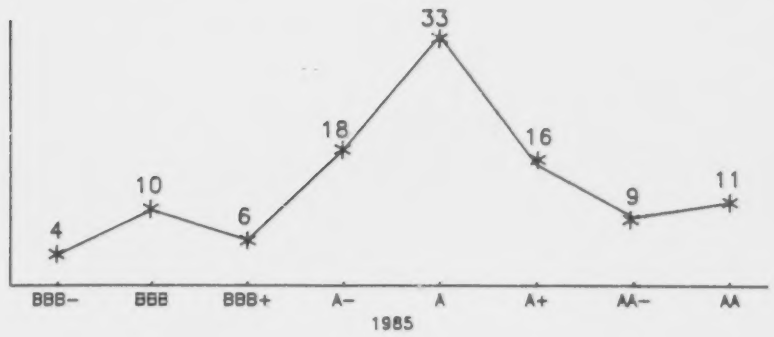
Year	# Upgrades	# Downgrades
1983	12	54
1984	10	50
1985	11	32 (A)
1986	4 (B)	70

Notes:
(A) Does not include 267 ratings lowered in conjunction with the Crum & Foster Intercompany Pool downgrading and 21 ratings lowered in conjunction with the Ticor Mortgage Insurance Co. downgrading.
(B) Does not include 50 ratings raised in conjunction with credit insurance provided by the State of California.

NUMBER OF NOT-FOR-PROFIT HOSPITALS RATED BY STANDARD & POOR'S
BY RATING CATEGORY







SOURCE: STANDARD & POOR'S CORPORATION

Chairman STARK. Mr. Elrod, prior to 1983, did hospital bonds enjoy a somewhat non-general obligation, but either industrial revenue or those for-profits, did they enjoy a higher credit standing generally than other service industries?

Mr. ELROD. It is a little difficult to estimate that one, Mr. Chairman. At that point I believe you would find that about 1,100 hospital bonds were rated out of the roughly 5,600 community hospitals. So you are looking at a better than average systematic distribution, if you will.

Chairman STARK. And is it not really a situation that before 1983 you more or less came as close to having a government guarantee as any other nongovernment agency bond? You really had a Federal Government to say we will give you the money to pay back your capital? While it may not have been good for a holder in due course, it comes pretty close to being a guaranteed income stream for those particular bonds, does it not?

Mr. ELROD. I think the market focused on the fact that the source of that cash flow, Mr. Chairman, was a good source, and that there was no doubt that those folks would be there.

Chairman STARK. Do you know any other industry in the country that has a guaranteed source of cash flow from the Federal Government, or did prior to 1983?

Mr. ELROD. No, sir, not that I could think of.

Chairman STARK. The Post Office is the only one I can think of, and it is arguable whether that is so. And I think therein lies my rebuttal to your statement. When you or I buy a Chrysler or anything else, we pay the sticker price. We do not pay the sticker plus dealer prep plus destination plus a return of capital to Mr. Iacocca. We pay a price, and he may in some years skimp on capital improvements; or he may take some of that profit and not report so much to the stockholders and build more. And I think that is what we are suggesting here.

There is one area that I think I agree with you, but I think we are talking about two different things. You indicate that the not-for-profit side has a disproportionate share of bad credit and charitable burden to bear. I do not think this is the place to deal with that.

I think you are right and I think we should reimburse them for that, but I think we should reimburse them in other ways. We should deal directly with the uncompensated care, charity cases, poverty cases or to bad debt.

I am willing to do that, pay them, but then let them decide, rather that a hospital did not even have to make a distinction, particularly at emergency room levels and other areas, whether a person has the money or not. They just go ahead and treat them, and then if for some reason they are not covered, we find a way to do it.

If we could do that, that would be a fair counter to your argument, would it not? They could then compete in the market along with everybody else?

Mr. ELROD. Yes, sir. I tried to restrict my comments to the way the external market might look at it. And if you can come up with a system like that, then great, but I am afraid with the information they have at hand——

Chairman STARK. And is it not fair that if we do reimburse, and we do not make them choose. They are somewhat indifferent, then, to the interest rate they have to pay? What argument do they give you for trying to save a few basis points if Uncle Sam, in effect, is going to make up the difference?

Mr. ELROD. I think the effect which the DRGs have had on the operating side should not go unnoticed. The information I guess I would direct your attention to is a survey which Modern Health Care, an industry publication, did in June of 1986.

Chairman STARK. But what I am getting at is you are dealing with a board. Let us assume for a minute that this committee is the board of some hospital in some community, and you are their investment banker, and we are trying to decide either which investment banker to select or how much of a bond issue to sell or whether or not to build a wing on the hospital, which our decision as to whether to build, say, 100 beds or 120 beds might very well be determined by the interest rate that we have to pay or the term or whatever else.

But if we can collect whatever we need from Uncle Sam, then there is no incentive for you as an investment banker to really try and convince them you are going to deliver the best rate because you figure that is all a matter of indifference in this whole level of negotiation, is it not, when Uncle Sam, in effect, is going to come back, and if you are off by five basis points, the taxpayers pick it up? I think that is the counter, again; that we ought to take those incentives, or disincentives, to economy out of the scale.

How else would you build it in? How would I be sure that you are doing the best job?

Mr. ELROD. I am not sure my experience dovetails with the description that you just laid out, although I can see in theory how that might happen. I think it is a competitive situation out there, and the statistic I was going to cite for you was that between 1984 and 1985, amongst multihospital systems, for-profit and not-for-profit, construction of new acute care hospitals dropped 46 percent. The operational costs estimated with those hospitals dropped 54 percent, I believe.

But the point is that, just on the operating side, I think there is a significant rude awakening that has been put in place that has put a clamp down on capital expenditures. I am not sure that people are going into this thing willy-nilly. If they were before, they certainly are not now.

Chairman STARK. Thank you very much. Mr. Levin?

Mr. LEVIN. Well, as I listened to your testimony, I was a bit perplexed. We are thinking of taking action under the DRG system because hospitals have had earnings that are "too high," and your testimony is that we should not involve capital in a DRG system because the credit position has deteriorated.

I do not know how you put those two things together.

Mr. ELROD. In terms of my written testimony, Mr. Levin, what I was suggesting was that the bond rating agencies are a surrogate for the market, and showing a tendency to downgrade.

Mr. LEVIN. Why would that be at the same time we are showing such healthy profits? True, it is under the DRG system. It does not

cover all the activities of the hospital. But how do you put those two things together?

Mr. ELROD. Well, one way I was trying to do it was the way that Mr. Stark effectively quoted, and that was to point out that profits over the near recent past have very little to do with the lender's decision when the lender is looking forward 30 years. And I would say that the credit position of the industry has deteriorated because, notwithstanding the past couple of years and the response of the industry to the economic model that you have put in place, is that they do not think you can sustain it over 30 years; and when you are setting yourself up for a contractual obligation to pay a fixed cost over that time, they are considerably uncertain as to whether you can meet that obligation.

So, yes, it is great that you have had profits, and I think what they are telling you is, "I hope you can continue to do that, but we do not think you can over 10 or 20 or 30 years."

Mr. LEVIN. Because? It is not clear why. We are talking about profits for more than one year, right, for several years.

Mr. ELROD. I think what the market is telling you, Mr. Levin, is that the cash flow, the total resources that the individual credit has to bring to bear to cover both their variable and their fixed expenses, unlike past years, is now called into question. The predictability of that amount being that can cover all expenses is now called into question; whereas, it was not that way up to the 1982 situation or 1983 situation.

Mr. LEVIN. So maybe the answer is the credit position has gone down because of a concern that Congress will insist on the lower profit margin.

Mr. ELROD. I did not say that. But, yes, I think that is a concern that the game keeps getting changed. You promised in 1983 to make it one of both winners and losers if you were good; now you are saying, wait a minute, too many of you have been good, and now we are going to ratchet back on the industry as a whole.

Mr. LEVIN. Well, it would be a reduction not to zero, but from 13, 14, 15 percent levels. And whatever the merits, it was not clear to me how you put those two things together.

I think we will have to digest your testimony, but where you say on the bottom of page 3 that the most likely losers under the HHS proposed system would be hospitals located in poor, already underserved communities, and that the likely winners would be wealthy suburban institutions—have you taken the HHS proposal and actually plotted that against hospitals in suburban areas and in inner city areas? Or is this kind of theory on your part?

Mr. ELROD. What I am doing there, Mr. Levin, is backing on the work that Alan Sager up at the Boston University School of Public Health has done. What, in effect, Mr. Sager concludes is that it is not bad management but it is where you happen to be that really is the primary cause, or has been in the past, of financial distress.

Mr. LEVIN. You have not taken the proposed system and actually looked at hospitals in each of these types of areas and deciphered the impact, right?

Mr. ELROD. No, sir.

Mr. LEVIN. You have just taken an assumption and are projecting from that.

Mr. ELROD. I would submit that if they have not over the past 2 years been able to build up their net worth, if you will, then it is highly unlikely under the system that is being proposed they are going to be any better off. But you are absolutely right.

Mr. LEVIN. It is really kind of, I will not call it speculation, but it is taking one assumption, applying a proposal to it, and coming out with a conclusion.

Mr. ELROD. Yes, sir.

Mr. LEVIN. No further questions. Thank you. If you have any details on that, I would be interested to see them.

Mr. ELROD. Okay.

Mr. PICKLE. Do you have any figures that show how the proposal affected the credit rating of the hospital?

Mr. ELROD. Yes, sir. At the back of my written testimony there is some information from Standard & Poor's which indicates that the credit position, both on the for-profit company side, and the not-for-profit side has gone down during the 1980's.

Mr. PICKLE. And it has been a negative impact?

Mr. ELROD. Negative trends. Yes, sir.

Mr. PICKLE. Thank you, Mr. Chairman.

Chairman STARK. Thank you very much, Mr. Elrod.

Mr. ELROD. Thank you.

Chairman STARK. I appreciate your taking the time to be with us here today.

Our final witness is Jack Owen, the vice president of the American Hospital Association. Jack, welcome back to the committee, and we will look forward to your ability to summarize, and compromise between the various positions that have been presented today.

Why don't you proceed in any manner that you are comfortable with.

STATEMENT OF JACK OWEN, VICE PRESIDENT, AMERICAN HOSPITAL ASSOCIATION

Mr. OWEN. Thank you, Mr. Chairman. It is a pleasure to be here today with the committee.

I wish that I could say I came here today to say that I am really behind the prospective payment system, and inclusion of capital in the system, but I cannot.

I have to say that we believed in the prospective payment system, we wanted it to work, and as Mr. Gradison knows, we have worked closely with him in the past, but we are in a situation where we do not think it is proper, at this time, to put capital into that prospective payment system.

And let me say a few things on behalf of what some of the other witnesses have said, and in reference to my testimony why I feel this way, and why the association feels this way.

A year ago, we sat here and listened to HHS come forward with a program to include capital in the prospective payment system. It was a 5-year transition, and they had many other things they were going to throw out. It was going to be the answer. And now we see another one is better, much better, but it is still not providing the kind of equity that we feel is necessary.

We have heard that it is going to make hospitals more efficient, that it is not a question of saving money, that Congress has already done that, and what we are looking for is efficiency.

We do not see the efficiency that is going to follow in this because of a couple of reasons. One, you have already taken 10 percent, or leading towards 10 percent coming out of capital, and if you are going to borrow a dime and you are only going to get 9 cents back, you are going to be awfully careful how you borrow.

And if you look and see what has happened—you heard the previous witness on the bond ratings of hospitals—and if you take a look also at what the borrowing has been in this last year, of tax-exempt bonds in 1986, in 1985 it was about $32 billion, and before tax reform came in it had dropped down to about $5.9 billion this past year, in 1986.

So it is already happening. We do not see the capital out there, and it is not going to happen.

The next thing I would say is that we have listened to ProPAC, and we heard Dr. Cohen, and what he said made a lot of sense, but you have got to take into consideration that so far, Congress and the adminstration have only listened to ProPAC when it is in their best interest. The 2.3 percent increase on the DRG update was not accepted, and it was not accepted last year.

And so if we pick out just those things that are going to save money——

Chairman STARK. Would you rather we had listened to the administration?

Mr. OWEN. Well, the administration this year is at least up to 2 percent.

Chairman STARK. No, last year.

Mr. OWEN. Oh, last year? No.

Chairman STARK. When we listened to ProPAC.

Mr. OWEN. No.

Chairman STARK. All right. Come on, give credit where credit is due.

Mr. OWEN. I will be happy to do that. But as Dr. Cohen stated, in Maryland they were able to do this quite rapidly.

But you have to remember that they do not have a national, or a State rate even in Maryland. They are not averaging all of those hospitals. Each hospital appears before a——

Chairman STARK. They have statistics in Maryland. [Laughter.]

Mr. OWEN. Well, I am happy, Mr. Chairman, to provide you with some statistics that I have right here, that is a quarterly report that comes from the American Hospital Association, and I will promise you that I will make it available to you every single quarter. It is right up to date.

But the issue still is that we are talking about a national rate for the country, and we are not talking about one small State in which each hospital can come in and sit down and appeal if they had a problem.

So there is the whole question of equity. So the real question in our mind is why you want to incorporate capital into PPS—you have got the savings. Congress has said there is a way to handle this, continue the passthrough with the 10-percent reduction coming up—we do not particularly like that, but it is there—and

continue in that fashion because it is more equitable from the standpoint that everybody is affected in the same fashion.

The other problem we have, of course, is the splitting of the capital, the movable and fixed. You heard it reported that the American Hospital Association has guidelines, but not all hospitals follow the guidelines, and the way money is borrowed, it frequently turns out that determining what will be movable and what will be fixed affects the amount of money borrowed.

And our look at the field shows that there is a percentage of movable that ranges from 1.6 percent of total operating cost to 4.3 percent. And you take that and split that into a 3-year phase-in versus a 10-year phase-in, and you can see some real problems occur, and problems that we have looked at with hospitals both small, large, and in different parts of the country, and they do show that there are some big losers as you move into that particular aspect.

Now Mr. Chairman, you raised a question, I think appropriately, about what other industry had this guaranteed kind of payback on bonds.

I would ask another question: what other industry do you know of that has to participate in a program, provide care in which a price is set, and which they cannot negotiate, or have no way of setting it. So I think that——

Chairman STARK. It is my understanding that no hospital in the country has to participate if they do not want to.

Mr. OWEN. Well, I think you will find that there are some laws that require, under civil rights acts, and so forth, and Hill-Burton Acts, that require hospitals to participate, and you cannot just walk away.

Chairman STARK. All hospitals?

Mr. OWEN. All hospitals who have participated——

Chairman STARK. I do not think so.

Mr. OWEN. Not all hospitals, but all hospitals who have participated in any of those Federal programs.

Chairman STARK. Well, that is understandable.

Mr. OWEN. Well, that is practically all hospitals.

Chairman STARK. Those were all voluntary, too. Nobody had to participate in Hill-Burton, did they?

Mr. OWEN. That is correct.

Chairman STARK. This is a voluntary country. You know, there are those of us who believed a year ago that we ought to have a system somewhat different, and we lost to the American Hospital Association. You did not want it. If you want to re-fight that battle, that is all right with me.

Mr. OWEN. All right. Let me just finish, and say, that I think that the most important thing that we really feel that is missing in what the administration wants to do, and anything that you attempt to do, is that there has to be some kind of an exceptions approach.

There are hospitals that are going to be hurt, and you just cannot try to average out capital. There are those recently incurring capital costs, those who are about ready to take on a major project, and some hospitals that are in the middle of a cycle but have a high capital cost.

In summary, I would just say at this point in time, we would recommend that you do not change the system that we have got. It is not going to save any money. It is going to create a lot of political upheaval, and it is going to create some real problems for some of our hospitals that have some debts that they must pay off, and which are not going to be able to pay them off under a system that tries to average out capital costs.

[The statement of Mr. Owen follows:]

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STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON WAYS AND MEANS
OF THE
UNITED STATES HOUSE OF REPRESENTATIVES
ON
MEDICARE CAPITAL PAYMENTS

MAY 4, 1987

SUMMARY

The AHA opposes the incorporation of capital in PPS prices because none of the incorporation proposals currently being considered provides for adequate and equitable payment. The difficulty in developing an adequate and equitable capital payment policy stems from the wide diversity among hospital capital cost cycles. None of the proposals under consideration adequately recognizes individual hospital capital needs either in the calculation and update of the capital add-on amount or in the length and structure of the transition.

INTRODUCTION

Mr. Chairman, I am Jack Owen, Executive Vice President of the American Hospital Association (AHA). On behalf of its 5,600 institutional members, the AHA welcomes this opportunity to comment on the issue of Medicare payment for capital expenses.

BACKGROUND

In 1983, when Congress developed the Medicare Prospective Payment System (PPS), it understood that capital costs were significantly different from operating costs. While it devised and put into law a new incentive system to pay hospitals for their operating costs under Medicare, Congress deferred action on capital payments until October 1986.

Since PPS was enacted, discussions about how to incorporate Medicare hospital capital payments into operating prices have occurred both in Congress and within the hospital industry. Absent a consensus on a capital incorporation method, Congress decided to continue the current pass-through system, albeit at reduced spending levels.

Passed as part of the Omnibus Budget Reconciliation Act (OBRA) of 1986 (P.L.99-509), the modified cost pass-through approach reduces capital-related payments by 3.5 percent for Fiscal Year (FY) 1987, by 7 percent for FY 1988, and by 10 percent for FY 1989. However, sole community providers are exempt from the payment reductions.

Under P.L.99-509, if Congress does not exercise its prerogative to legislate on this matter, the Secretary of the Department of Health and Human Services (HHS) has the authority, beginning in FY 1988, to incorporate capital-related costs into PPS within the budget parameters established by that law. It is also important to understand that if the Secretary fails to incorporate capital into PPS by regulation--or is prohibited from doing so--Section 1122 capital expenditure review requirements will become mandatory in all states unless Congress amends the law.

Over the past two years, the government and the hospital field have attempted to develop an adequate and equitable method for folding Medicare capital payments into PPS operating prices. Despite the best efforts of all parties to identify a solution, no fair system has yet been proposed. Because none of the capital proposals presents an adequate and equitable method of paying for these expenses, maintaining the current capital cost pass-through would be the most appropriate and equitable approach, particularly since Congress already has established limits for Medicare capital payments for the next two years.

DIFFICULTIES IN INCORPORATING MEDICARE CAPITAL PAYMENTS IN PPS PRICES

The difficulty in developing an equitable capital payment policy is due to the wide diversity among hospital capital cost cycles. Hospitals make major capital expenditures or commitments, such as replacing or modernizing physical plant or major fixed equipment, very infrequently. At the point that this commitment is made, a hospital's capital costs are fixed for a considerable period of time and, unlike operating expenses, are generally beyond the hospital's control. Thus, differences in where hospitals stand in their capital cost cycles result in wide differences in their capital commitments (or amounts of debt) and, consequently, in their immediate and future capital needs. The differences among hospitals in capital requirements are further complicated by the fact that this variation cannot be accounted for by commonly used hospital characteristics such as location, ownership, size, teaching status, geography, labor costs, or intensity of care.

The approaches that have been proposed to fold capital payments into PPS to date would be disadvantageous to a significant portion of hospitals. None of these proposals adequately recognizes individual hospital capital needs either in the calculation and update of the capital add-on amount or in the length and structure of the transition. Hospitals most adversely affected by these incorporation proposals would be those institutions that have recently incurred major capital commitments and those that must undertake major projects in the near future. Among the latter group of hospitals are institutions that depend most on government payers--those serving substantial poor and elderly populations under Medicare and Medicaid--many of which have old physical plants that are greatly in need of capital for the purposes of renovation and modernization.

A switch from the pass-through for capital to prospective payment would severely penalize some hospitals for past decisions they cannot change. Unlike operating costs, hospitals can do little to change capital costs once incurred. A radical change in Medicare's capital payment rules on which hospitals have based capital investment decisions would cause significant, undeserved financial hardships.

Another potential difficulty inherent in capital incorporation is that lender uncertainty about debt repayment will increase. It is absolutely critical that hospitals avoid defaults because they would have serious repercussions affecting the entire health care field. It is also noteworthy that many hospital capital projects are backed with federal guarantees such as the FHA 242 program. Greater uncertainty means higher interest costs, which for some hospitals may mean loss of access to capital markets altogether. Moreover, eliminating the pass-through could affect the ability to refinance, which reduces Medicare capital payments for interest.

Under the continued pass-through, hospitals would be better assured of being able to meet current debt service requirements. Thus, there would be less likelihood of hospital bond defaults. In addition, financial markets would have more confidence in the ability of hospitals to meet their financial commitments. This would help hospitals acquire needed capital at reasonable rates and, consequently, would help keep costs down for the industry as a whole.

ADMINISTRATION'S CAPITAL INCORPORATION PROPOSAL

The Administration's FY 1988 budget recommends that capital payments be folded into PPS. Based on our knowledge of some of the details of the notice of proposed rulemaking, the Administration's policy would incorporate capital payments for movable equipment into PPS operating prices over a two-year transition period. Capital payments for fixed equipment/plant would be folded in over a 10-year transition period. During the transition periods, the capital add-on factor would be a blend of a hospital-specific rate and a federal rate. For movable equipment, the hospital-specific rate would be blended at 67 percent in the first year (FY 1988) of the two-year transition period and 33 percent in the second year (FY 1989), resulting in a federal rate beginning in FY 1990. For fixed equipment/plant, the blend would be more heavily weighted toward hospital-specific costs in the early years of the 10-year transition to federal rates.

The Administration's proposal is consistent with provisions of P.L.99-509 that require that aggregate Medicare payments for capital under any regulatory proposal for incorporating capital payments into PPS operating prices be equal to the aggregate Medicare payment amount that would have been made under this act if capital payments were not incorporated. The Administration's proposal would achieve "budget neutrality" for FYs 1988 and 1989 by reducing both the hospital-specific capital payment rates and the federal capital payment rates. But, it is important to recognize that the Administration anticipates annual savings of $100 million or more beyond FY 1989.

CONCERNS WITH INCORPORATION APPROACHES

AHA does not support folding capital into PPS operating prices because none of the incorporation proposals currently being considered provides for adequate and equitable capital payments both during and after the transition to federal rates. The government's failure to meet these conditions is the basis for AHA's current position in support of the continuation of the pass-through.

Adequacy

AHA opposes the Administration proposal on the incorporation of capital. Our opposition is based on several considerations. The first and most important of these is that it provides no assurance that "capital" payments will in fact be adequate in light of current and needed future capital obligations. Although the proposal is "budget neutral" initially, as required by current law, in the later years there is no assurance that the increase in the capital component of the market basket will keep pace with actual capital requirements. Until such assurances are provided, it is impossible to support the incorporation of capital into the prospective pricing system.

Equity

The second reason for our opposition to the Administration's proposal is equity. The Administration's proposed incorporation approach will significantly, and we believe indiscriminantly, disadvantage a substantial portion of hospitals. While, as the Prospective Payment Assessment Commission (ProPAC) has demonstrated, the "average" hospital facing "average" circumstances will be able to make the transition from cost-based to PPS-based capital payments, the issue is whether non-average hospitals in atypical circumstances will be able to make the transition--and what to do about it if they cannot. As indicated earlier, there is a wide diversity among hospitals in their capital cost cycles so any definition of "average" will apply only to a minority of hospitals.

Moreover, AHA is also concerned about the approach of splitting capital payments between fixed/plant and movable/equipment. Rapid incorporation of payment for movable equipment costs presumes that all hospitals have about the same ratio of movable equipment capital costs to operating costs. In fact, movable equipment capital costs vary substantially among hospitals such that incorporation of these costs would result in windfall payments to some hospitals and significant shortfalls to others. As a percent of total operating costs, movable equipment capital costs can vary from less than 1.6 percent to more than 4.3 percent. The short two-year transition would be particularly inappropriate for those hospitals with substantial movable capital costs because the transition to federal capital payments would occur very rapidly.

Our analysis of approaches similar to those proposed by both ProPAC and the Administration indicates that incorporation will sharply increase the number of hospitals experiencing substantial shortfalls between their capital payments and capital requirements. In our analysis we directly compared hospitals' capital costs to the amounts that they would receive once capital is fully incorporated into the prospective pricing system and at various points during the transition. This preliminary analysis indicates that under the "split transition" for fixed and movable equipment:

- nearly 30 percent of small hospitals (fewer than 1,000 admissions annually), and more than 30 percent of large hospitals (8,000 or more admissions annually) would experience a capital shortfall of 10 percent or more;
- nearly 20 percent of small hospitals (fewer than 1,000 admissions annually), and more than 15 percent of large hospitals (8,000 or more admissions annually) would experience a shortfall of 30 percent or more;
- approximately 40 percent of mid-sized hospitals would experience losses of 10 percent or more, and approximately 24 percent of these hospitals would experience losses of 30 percent or more;
- about 18 percent of all rural hospitals, and about 25 percent of all urban hospitals would experience a loss of 30 percent or more; and
- more than one-fifth of all non-teaching, and more than one-fourth of all teaching hospitals would experience a shortfall of 30 percent or more.

Exceptions Policy

Finally, another concern with the Administration's proposal is the lack of an exceptions policy. However, AHA contends that an exceptions policy is of critical importance to any incorporation approach.

In its proposal, which is very similar to the Administration's, ProPAC recognizes this problem, as an appeals or exceptions mechanism is proposed in ProPAC's April 1 recommendations to the Secretary. ProPAC recognizes that a number of hospitals may have problems adapting to the new system, as it calls for "strict criteria" to limit the number of hospitals that would actually receive a capital payment adjustment. But, ProPAC was not able to define the criteria that should be applied. In fact, three classes of hospitals would require an appeals or exceptions mechanism:

- hospitals that have recently incurred major capital commitments;
- hospitals that must undertake major projects in the near future; and
- hospitals that may be moving toward the middle of their capital cost cycles but are highly leveraged and, thus, have relatively high capital costs.

Because we believe that a substantial number of hospitals would require special treatment under the Administration's plan, it calls into question the entire basis of the Administration's capital incorporation proposal, making it impossible for the hospital industry to support this approach.

Section 1122 Review

The AHA believes that the federal role in state capital expenditure review is no longer necessary. Recent moderation in hospital capital spending demonstrates that hospitals are responding to changes in utilization and the incentives for efficiency inherent in PPS. Rates of increase of hospital capital expenditures for community hospitals have been lower in 1983-1985 than they were in 1981 and 1982. Moreover, the average of the rates of increase in capital expenses for 1985 and 1986 is over 6 percentage points lower than for 1983 and 1984. Given this clear indication of moderation in hospital capital spending, mandatory federal Section 1122 review is not necessary to control capital expenditures.

Under current law, if incorporation of capital-related payments is not implemented before October 1, 1987, no Medicare payment may be made for capital-related costs unless states have agreements with the Secretary under Section 1122. However, if the Secretary implements a proposal for capital incorporation, mandatory Section 1122 review is not necessary. Therefore, it is our understanding that the Administration's notice of proposed rulemaking incorporating capital payments into PPS operating prices would adjust the federal portion of the capital-related payment amount to exclude those costs that have not received Section 1122 approval.

RECOMMENDATIONS

AHA has devoted and will continue to devote significant resources to the development of a fair and adequate method of paying for capital by the Medicare program. On the basis of all currently available information, AHA has concluded that the only method of paying for capital that provides reasonable assurances of adequacy and equity is a continuation of the pass-through. Since Congress has already established Medicare capital payment limits through FY 1989, retention of the capital pass-through will be budget-neutral. This position has the broad support of the hospital field and reflects a strong concensus among hospitals in all parts of the nation that none of the methods of paying for capital that has been proposed would result in either adequate or equitable payment.

Therefore, AHA recommends that any action to incorporate capital into PPS be delayed at least until October 1, 1989, to provide additional time for development, evaluation, and refinement of an adequate and equitable method of paying for capital-related costs. Therefore, Congress must act before September, 1987 to prohibit the HHS Secretary from issuing regulations that would incorporate capital-related costs in PPS.

Chairman STARK. Jack, I guess I hear you. I have trouble with understanding why you oppose it, in summary, because it is not adequate or equitable.

Mr. OWEN. That is right.

Chairman STARK. Now what is equitable about the situation suggested by the administration earlier where if a hospital has 25-percent occupancy and it is all Medicare, the Federal Government, in effect, pays 100 percent of the mortgage payments? Is that equitable?

It is certainly adequate, but I mean, why is that fair?

Mr. OWEN. Well, I do not know if I could argue that case as being fair, I would have to agree with you, but, on the other hand, can you show me one hospital that has just one patient, that is a Medicare patient? And when we find that hospital I am willing to go in there with you and change it.

Chairman STARK. I am talking about the system now.

Mr. OWEN. All right.

Chairman STARK. And I guess what I am saying is, that obviously, when you are in a cost-recovery system, which we used to be, people give you the labor costs, the equipment costs and the fixed costs, all these things, and we reimburse them.

We said we are going to cut that out in 1983. Now what I cannot understand is why—and I guess I do not know of any other industry that even does it this way in the sense of accounting. Why is that a different kind of a cost that ought to be singled out for full reimbursement as opposed to labor or anything else, or advertising? Or pensions? Why capital in the sense of any kind of business judgment for any business?

Can you give me a reason for picking capital by itself?

Mr. OWEN. No, no, let me comment on it because I do not disagree with you, philosophically, that capital is part of a price if you are in a pricing system.

The issue, though, is not that capital should or should not go into the DRG system, in my opinion. The issue is that so far, what we have seen happen with the DRG system, has not led us to believe, or have any faith that moving capital into the system is going to be advantageous or even acceptable.

Chairman STARK. Okay. Now you are at——

Mr. OWEN. No. Let me continue just a second more.

Chairman STARK. Okay.

Mr. OWEN. Because we started out with the idea that the DRG system was going to be prospective, and that we are going to move forward with a market basket update with a technological factor added to it. Yet we have never gotten an upgrade factor that was even close to what was anticipated, or that we could count on. There is a feeling that with capital you can do less maneuvering. Once you have a mortgage you are stuck with a mortgage.

With other operating you can let people go, you can do other things to improve your productivity. How do you improve your productivity on a building that you have just built? You cannot. Okay. You cannot fire it; you are stuck with that mortgage.

Without any kind of assurance that there will be some kind of predictability in that update factor—and that is the key, the update factor—and if you throw capital in there and do not do any-

thing with the update factor, how are hospitals going to pay off their debts?

Chairman STARK. I have to agree with you. I went through this argument on a guaranteed return on equity which is the most ludicrous of all pipe dreams that was raised by the for-profit hospitals. But I think we have buried that one.

Now the second-most ludicrous is if somebody were going to pay all my fixed costs for plant and equipment, somehow, at a guarantee. So I would be indifferent as to how much interest I paid. The more the merrier.

And with the advent of junk bonds, it is amazing, if you are willing to pay 13 percent in an 8 percent market, you can part an awful lot of ignorant investors from their dollars awful quickly, and you can do a lot of harm, actually. So philosophically, the other side is that it is a bad way for the Government to go, particularly with no cost containment.

We have argued, and you have heard us argue here, we do not want to get into reimbursing pharmaceuticals without cost containment.

What you are basically telling me is that we are taking the lid off. There is no cost containment on capital, right?

Mr. OWEN. No, I——

Chairman STARK. If you grandfather.

Mr. OWEN. Well, I think there is a cost containment; you already cut out 10 percent.

Chairman STARK. But I mean that is——

Mr. OWEN. Three and a half, 7, and 10.

Chairman STARK. Eighty percent is, and then they pay 72 percent interest. That is not so bad. That is not cost containment, that is just——

Mr. OWEN. Well, but it is cutting back on the reimbursement for capital.

Chairman STARK. But wait a minute. When you talk about adequacy, I think you are being disingenuous on the 10 percent because I do not think anybody is out of pocket on 10-year life, or better, or less, if they are getting depreciation and interest. They are getting their money back. They may not be getting it as fast as they thought, but there is nobody who is bleeding to death because of those requirements.

You could apply your argument, I suppose—and I will use it toward graduate medical education. There are those who are saying we ought to give something extra for it. And I guess it is something you have to pay for, just like buildings, but it always seems to me the best way to pay for it is to find out what it costs, and who is paying it, and then figure out a way to get a reasonable amount.

In the instance of capital, it seems to me that is a management decision, and I——

Mr. OWEN. I do not disagree with you.

Chairman STARK. I cannot find a good reason, that is going to lead to fairness, equitability, and adequacy from the Government's standpoint, if we just continue to let them recapture their capital costs. There is no control.

How do we protect the taxpayers under that system?

Mr. OWEN. Well, I think the way you protect the taxpayers is through the setting of the price, that is what you are doing, and you are protecting them in every way, shape and form, but it seems to me——

Chairman STARK. No, no. But we are paying everything on capital. How do we prevent them from going out and just spending?

Mr. OWEN. But the issue really is, the real problem is, what about those who have already committed funds at the present time?

Chairman STARK. What about the ones who are going to go out and spend?

Mr. OWEN. Well, if we could solve the problem of how to make sure that all those who are committed are not going to be left high and dry because of a change in the way that the Government works——

Chairman STARK. But your solution is to give them their money back, whatever it costs. Then the new facilities are going to say we want that, too.

Mr. OWEN. Well, the percentage of what Medicare's responsibility is.

Chairman STARK. And I just say there is no cost containment on the other side at all, and I do not think, as representatives of the taxpayers, that we can sign onto that.

Mr. OWEN. But we have not seen that happen, have we, in the past year?

Chairman STARK. Oh, I do not know. You are telling me that with a 60-percent national occupancy there has not been overexpansion? I would find that hard to believe.

Mr. OWEN. No, I said the overexpansion took place before that, before that ever happened.

Chairman STARK. But maybe because we were reimbursing for capital people are going out and higgledy-piggledy building new hospitals that they cannot now fill with patients.

I think there is a more direct relationship there. That is why we have overexpansion, because there was no control. Build a new one. Just like the Republicans—borrow and spend, you know.

Mr. Levin.

Mr. LEVIN. Now I went to an undergraduate school where we had six hours of multiple choice at the end of a year, and I think your testimony would make a good multiple choice test, and I mean that respectfully.

It is well and good to give a number of arguments, but I cannot really figure out, from your testimony, what is the thrust of the opposition.

I wrote down four different arguments, or, at least it seems that way, and if I asked a student, tell me, what is the central argument of AHA on this, I am not sure which one I would say is the correct answer, based on your testimony.

On page 11, you seem to be saying that there really is not a necessary Federal role. That is kind of a bald statement, right at the top there. "The AHA believes that the Federal role in State capital expenditure review is no longer necessary."

Then, on page 12, the second part of my multiple choice question would be something like this: Are they saying that you are working

on it, and that it is premature to move? That you have been devoting a lot of resources, and you have not come up with an answer yet?

Then, earlier, you seemed to be saying that this is too diverse a subject matter. On pages 8 and 9, there is too much diversity here between types of capital investments and also, types of hospitals.

But then, on page 10, you seem to be saying that it is the lack of an exceptions policy. So let me just ask you to boil it down.

Mr. OWEN. OK.

Mr. LEVIN. If there were an exceptions provision in the HHS proposal, would you support that kind of an approach?

Mr. OWEN. If there were an exceptions policy within the proposal, and if there were some assurance that capital updates would be adequate, but nobody can give us that assurance. So the real issue here is one of equity, and although it may sound like the testimony goes all over the map, you have hospitals, for instance, the hospitals in Michigan, which are at different points in the borrowing cycle.

Mr. LEVIN. Right.

Mr. OWEN. Many of them are in a situation where they have to repay some of these tax-exempt bonds that they committed 2 or 3 years ago, and the question is will they, in the kind of a situation that the administration is proposing, be able to get enough money to make the payments on those bonds?

Mr. LEVIN. All right. The fact that you present a number of alternatives is not a surprise. That is true of most testimony. I just thought it was rather striking here.

It really was not clear, what was the thrust of the testimony, or maybe it had four thrusts. But you are right about Michigan. There is a lot of concern, and we were given an analysis that talked about "winners and losers" in the various regions.

But you have heard the administration, and the commission's response, that with a 10-year phase-in, that it should handle it. What I am really trying to do is to ask you—because what you say is important to this subcommittee—we are going to have to wrestle with this the way the law is written.

If we handle the transition exceptions area, do you think you could support prospective payment?

Mr. OWEN. I think if you could put in an exceptions policy and did not split movable and fixed——

Mr. LEVIN. But I mean there are some differences. You are not suggesting we——

Chairman STARK. Shall we make it all a 2-year transition?

Mr. OWEN. No. I was thinking about 15. [Laughter.]

Mr. LEVIN. I mean, don't make your exceptions so broad that it not prove the rule, but eliminates the need for a rule. But I think you would agree there has to be some distinction between fixed and movable capital.

I do not think you would want to lump it all together. You see, this is where I am confused, whether you really think this whole area is so unworkable that we should not touch it, or whether it is an issue of exceptions.

Mr. OWEN. I think it is unworkable from a standpoint of equity.

Mr. LEVIN. All right. That is a clearcut position. so what you are really saying is, there is no way for us to put together capital within prospective payment, and achieve equity?

Mr. OWEN. There is a way to do it, but I do not think you want to spend the money to do it that way, and that is the problem.

Mr. LEVIN. OK.

All right. That is clear. It may be too clear, we may be uncomfortable with that answer, but at least it is clear. Thank you.

Chairman STARK. Mr. Pickle.

Mr. PICKLE. Thank you, Mr. Chairman.

Mr. Owen, in my State of Texas, last year alone, we lost somewhere between 15 and 20 hospitals, so we are not just concerned about overproduction of hospitals, or overconstruction. We are concerned about these closures.

Now, if we were to adopt this proposal that we have before us, what effect would that have on a State like Texas?

Mr. OWEN. Looking at the statistics we have and the money that were borrowed in Texas, it looks like you have about 50 hospitals that would be in pretty serious trouble.

Mr. PICKLE. How many?

Mr. OWEN. About 50 hospitals would be in serious trouble under the administration's proposal. Now that is 50 out of—what do you have—345 hospitals I think, something like that.

Chairman STARK. Would the gentleman yield. Where do those numbers come from?

Mr. OWEN. Where do those numbers come from?

Chairman STARK. Yes.

Mr. OWEN. They come from the hospitals, and the information that we collect on our uniform reporting to the HA..

Chairman STARK. They do not send them to us.

Mr. PICKLE. Well, I would like to see that list of hospitals at a later time.

Mr. OWEN. I will be happy to give them to you.

Mr. PICKLE. Fine. Thank you.

[The information follows:]

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Below is a listing of most Texas nonprofit hospitals that have issued major (over $5 million) tax-exempt bonds in 1984 through 1986. The table includes, from left to right, the state in which the hospital is located, the date of the bond issue, the issuing authority, and the name of the hospital. Hospitals most adversely affected by the Administration's incorporation proposal would be those hospitals, like the Texas hospitals listed here, that have recently incurred major capital commitments.

ST	DATE	ISSUER	HOSPNAME
TX	12384	COASTAL BEND HOSP AUTH	SPOHN HOSP
TX	20984	LUBBOCK HLTH FACS DEV CORP	ST JOSEPH HLTH SYS
TX	21584	TYLER HLTH FAC!L DEV CORP	TYLER PSYCHIATRIC HOSP
TX	30184	AMARILLO HLTH FAC CORP	HIGH PLAINS BAPTIST HSP
TX	31284	SOUTHMOST TEXAS HLTH FACS AUTH	VALLEY COMMUNITY HOSP
TX	32884	LUBBOCK HLTH FACS DEV CORP	METHODIST HOSP
TX	42584	BEXAR CO HLTH FACS DEV CORP	SW TEXAS METHODIST HSP
TX	41184	DALLAS CO HOSP DIST	
TX	50184	HARRIS CO HLTH FACS DEV CORP	SCH HLTH CARE SYS
TX	52484	TARRANT CO HLTH FACS DEV CORP	FT WORTH OSTEO HOSP
TX	51184	BEXAR CO HOSP AUTH	SANTA ROSA MED CTR
TX	51684	HARRIS CO HLTH FACS DEV CORP	
TX	51684	TEXAS HLTH FACS DEV CORP	
TX	60184	HARRIS CO HOSP DIST	
TX	72584	NO CNTRL TEXAS HLTH FACS CORP	PRESBYTERIAN MED CNTR
TX	72584	NO CNTRL TEXAS HLTH FAC CORP	PRESBYTERIAN MED CTR
TX	81784	HENDERSON CO HOSP AUTH	LAKELAND MEDICAL CTR
TX	81484	NO TEXAS HOSP AUTH	BETHANIA HOSP
TX	91484	TARRANT CO HLTH FACS DEV CORP	ST JOSEPH HOSP
TX	91484	TARRANT CO HLTH FACS DEV CORP	ST JOSEPH HOSP
TX	91384	HARRIS CO HLTH FACS DEV CORP	MEMORIAL HOSP
TX	92684	EL PASO CO HOSP DIST	RE THOMASON GEN HOSP
TX	90184	WACO HLTH FACS DEV CORP	HILLCREST BAPT MED CTR
TX	91884	HARRIS CO TEXAS	HARRIS CO PSYCH HOSP
TX	103084	RIO GRANDE VLLY HLTH FACS DEV CO	VALLEY BAPTIST MED
TX	102384	HUNT MEMORIAL HOSP DIST	
TX	112184	HARRIS CO HLTH FACS DEV CORP	MEMORIAL HOSP
TX	111484	MONTGOMERY CO HLTH FACS DEV CORP	WOODLANDS MED CTR
TX	111584	TOM GREEN CO HLTH FACS DEV CORP	ST JOHNS HOSP
TX	111584	MCALLEN HLTH FACS DEV CORP	
TX	111484	AMARILLO HLTH FACIL CORP	

ST	DATE	ISSUER	HOSPNAME
TX	50185	CHEROKEE CO HLTH FACS DEV CORP	NAM TRAVIS MEM HOSP
TX	50185	HOUSTON HLTH FACS DEV AUTH	JEWISH COMM CTR HOUSTC
TX	60585	AMARILLO HLTH FACIL CORP	HIGH PLAINS BAPTIST HS
TX	60385	HIDALSO CO HOUSING FIN CORP	MISSION HOSP
TX	61885	MCALLEN HLTH FACS DEV CORP	
TX	62785	MONTGOMERY CO HOSP DIST	
TX	61885	TEXAS HLTH FACS DEV CORP	
TX	61885	AMARILLO HLTH FACIL CORP	
TX	72685	AMARILLO HLTH FACIL CORP	HIGH PLAINS BAPTIST HS
TX	72485	NUECES CO HLTH FACS DEV CORP	DRISCOLL CHILDRENS HSP
TX	71285	WACO HLTH FACIL DEV CORP	HILLCREST BAPT MED CTR
TX	82685	HARRIS CO HLTH FACS DEV CORP	MEMORIAL HOSP SYS
TX	82685	HARRIS CO HLTH FACS DEV CORP	MEMORIAL HOSP SYS
TX	80785	NO CNTRL TX HLTH FACS CORP	GARLAND MEMORIAL HOSP
TX	81385	TEXAS HLTH FACS DEV CORP	
TX	80185	BEXAR CO HLTH FACS DEV CORP	INTER HLTH TRUST
TX	80885	DALLAS CO HOSP DIST	
TX	92685	TARRANT CO HLTH FACS DEV CORP	HARRIS METHODIST HLTH
TX	92485	LUBBOCK HLTH FACS DEV CORP	ST JOSEPH HLTH SYS
TX	91285	ABILENE HLTH FACS DEVELOP CORP	HENDRICKS MED CTR
TX	91785	TOM GREEN CO HLTH FACS DEV CORP	ANGELO COMMUNITY HOSP
TX	101485	MIDLAND CO HOSP DT	MIDLAND MEMORIAL HOSP
TX	103185	BELL CO HLTH FACIL AUTH	CENTRAL TX HLTH CARE
TX	111385	NORTH CNTRL TX HLTH FACS CORP	KAISER PERMANENTE MED
TX	112685	HARRIS CO HLTH FACS DEV CORP	DCH HLTH CARE SYS
TX	112185	BEXAR CO HLTH FACS DEV CORP	INCARNATE WORD HLTH SER
TX	110185	NORTH CNTRL TX HLTH FACS CORP	METHODIST HSP OF DALLAS
TX	112585	HOUSTON HLTH FACS DEV CORP	METHODIST HOSP
TX	112585	HARRIS CO HLTH FACS DEV CORP	ST LUKES EPIS HOSP TX
TX	112585	HARRIS CO HLTH FACS DEV CORP	ST LUKES HOSP
TX	112085	BEXAR CO HLTH FACS DEV CORP	SW TEXAS METH HOSP
TX	110785	TOMBALL HOSP AUTH	TOMBALL COMMUNITY HOSP
TX	111385	HARRIS CO HLTH FACS DEV CORP	
TX	112785	HUNT CO HOSP DIST	
TX	112685	TITUS CO HOSP DIST	
TX	120385	HARRIS CO TEXAS	SCH HLTH CARE SYS
TX	122184	COASTAL BEND HLTH FACS DEV CORP	SPOHN HOSPITAL
TX	121184	HOUSTON HLTH FACS DEV CORP	METHODIST HOSP
TX	120784	SILSBEE HLTH FAC DEV CORP	SILSBEE DOCTORS HOSP
TX	121784	HARRIS CO HLTH FACS DEV CORP	
TX	11085	ARLINGTON HOSP AUTH	ARLINGTON MEM HOSP
TX	32185	RICHARDSON HOSP AUTH	RICHARDSON MED CTR
TX	42485	HIDALSO CO HLTH SERV CORP	MISSION HOSP
TX	41685	DENTON HLTH FAC CORP	LUTHERAN GOOD SAMARITAN
TX	41985	TEXAS HOSP EQUIP FIN COUNCIL	
TX	50285	GRAND PRAIRIE HLTH FACS DEV CORP	DALLS FT WORTH MED CTR

ST	DATE	ISSUER	HOSPNAME
TX	121185	TOM GREEN CO HLTH FACS DEV CORP	UNIVERSAL HLTH SERVICES
TX	120485	AMARILLO HLTH FACS CORP	HIGH PLAINS BAPTIST HSP
TX	121185	TRAVIS CO HLTH FACS DEV CORP	ST DAVIDS COMM HOSP
TX	121685	HARRIS CO HLTH FACS DEV CORP	SAM JACINTO METH HSP
TX	121085	LUFKIN HLTH FACS DEV CORP	MEM MED CTR E TEXAS
TX	122485	NO CNTRL TEXAS HLTH FACS CORP	METHODIST HOSP OF DALLAS
TX	123085	NO CNTRL TEXAS HLTH FACS CORP	PRESBYTERIAN HOSP
TX	122385	EL PASO CO HOSP DIST	R E THOMASON HOSP
TX	120485	TEXAS HLTH FACS DEV CORP	COOK FT WORTH CHILD HSP
TX	123085	NO CNTRL TEXAS HLTH FACS CORP	PRESBYTERIAN MED HOSP
TX	120485	PARIS HLTH FACS DEV CORP	MCCUISTON REG MED CTR
TX	121285	TOM GREEN CO HOUSING FIN CORP	ANGELO COMMUNITY HOSP
TX	120685	ECTOR CO TECAS	MEDICAL CENTER HOSP
TX	121285	HARRIS CO HLTH FACS DEV CORP	
TX	122785	HARRIS CO HLTH FACS DEV CORP	YMCA GREATER HOUSTON
TX	122185	MONTGOMERY CO HOSP DIST	
TX	122785	BEXAR CO HLTH CO HLTH CORP	
TX	121085	BRAZOS CO HLTH FACS DEV CORP	
TX	122685	EL PASO HLTH FACS DEV CORP	
TX	22686	TEXAS HEALTH FACS DEV CO	ALL SAINTS SOUTHWEST HSP
TX	32486	AMARILLO HEALTH FACILITI	EVANGELEAL LUTH HOSP
TX	40186	HANSFORD CO HOSPITAL DT	-
TX	61686	ABILENE HEALTH FACS DEVE	-
TX	71086	HARRIS CO HOSPITAL DISTR	-
TX	71786	ANGLETON-DANBURY HOSPITA	ANGLETON-DANBURY GEN HSP
TX	80186	BELL CO HEALTH FACILITIE	-
TX	80486	NUECES CO HOSPITAL DISTR	MEMORIAL MEDICAL CTR
TX	81686	HARRIS CO-TEXAS	-
TX	81286	EDINBURG HOSPITAL AUTHOR	EDINBURG GENERAL HOSP
TX	80486	GALVESTON CO-TEXAS	MAINLAND CENTER HOSPITAL
TX	100686	DENISON HOSPITAL AUTHORI	TEXOMA MEDICAL CENTER
TX	102386	HARRIS CO HEALTH FACS DE	HERMANN HOSPITAL ESTATE
TX	111486	VICTORIA CO-TEXAS	CITIZEN MEDICAL CENTER
TX	112486	HARRIS CO HEALTH FACS DE	-
TX	112486	TARRANT HOSPTIAL DISTRIC	JOHN PETER SMITH HOSP
TX	111486	ARLINGTON HOSPITAL AUTHO	ARLINGTON MEMORIAL HOSP
TX	112186	IRVING HOSPITAL AUTHORIT	IRVING COMMUNITY HOSP
TX	122286	BRAZORIA CO HLTH FACS DE	COMM HOSP OF BRAZOSPORT
TX	122286	DALLAS CO HOSPITAL DISTR	-
TX	121786	BEXAR CO HEALTH FACS DEV	SAN ANTONIO CHILD CTR

Mr. PICKLE. Well, I judge that you are saying that this proposal would have a negative effect on hospitals.

Mr. OWEN. It creates a serious problem. Yes. That is correct.

Mr. PICKLE. Well, now, I asked earlier, what would happen under the so-called 1122 section. We do not have a certificate of need system now in our State, and many of the States have done away with it.

Mr. OWEN. Right.

Mr. PICKLE. So we leave that up to the State capital flow. Now we have got a moratorium that is going to expire on October the 1st. So if we do not do something we have to then say that, I guess, a new system goes into effect, or at least the moratorium is not continued.

Now what is going to happen then? I asked Dr. Anthony would you have to have a certificate of need, and I do not know that I got an answer from him on what is going to happen.

What do you think will take place at that stage, supposing we do not do something about extending the moratorium?

Mr. OWEN. Well, your State of Texas decides whether or not it is going to have a certificate of need—but the 1122 portion, as I understand it, would continue as a method of looking at capital expansion out there unless something is done by Congress to get rid of 1122.

Mr. PICKLE. Well, I am trying to see what would actually happen, procedurally. If we do not have the moratorium, then I guess you could continue on some kind of agreement if you worked it out with the Secretary. But if you do not do that, you go back to an installation of the old certificate of need, and that is going to replow old ground, and cost us a good bit of money.

I am trying to see what the option is going to be in my State, if we do not renew the moratorium.

Mr. OWEN. Yes. The only thing I can point to is that we see no new borrowing taking place, either in your State, or in other States, that amounts to anything.

There are no new hospitals being built. We are trying to keep the ones we have open. The number of tax-exempt bonds, for instance, has dropped dramatically in hospitals that are seeking those funds, and as long as the update factor continues to be so low as it has been, there is no way to save money in advance to continue to build. So that the market itself has had a depressing effect on capital expansion in your State, and in an awful lot of other States.

Mr. PICKLE. I asked one of the witnesses, earlier, what would happen to these rural hospitals, and he said well, some of them will be affected, but we think they can handle that situation by doing something or another.

I never did get an answer on what was really going to happen to these occupants in these small communities where they have two, three, four, five beds of Medicare patients. How is a rural hospital going to stay open if this new proposal were to----

Mr. OWEN. Well, it is going to be very difficult for a small and rural hospital because of the occupancy problem that they have, and unless they are a sole community provider, unless they get that designation, then the cost is just not going to be borne by this program because it is averaging, and somebody is going to win,

somebody is going to lose, and most of the smaller hospitals will have a tendency to be losers.

Mr. PICKLE. I have reservations, Mr. Chairman. Thank you very much.

Chairman STARK. Well, Jack, thank you, too. I do have a question. You seem to suggest that it is a bad situation to see the amount of new capital issued decline?

Mr. OWEN. No.

Chairman STARK. No? That is not what you——

Mr. OWEN. Not necessarily at all. I think that it is happening. My point is that I think the market, or what has occurred in the hospital field has been good for the field, and I do not think we need to have much more capital——

Chairman STARK. Is the occupancy rate going up?

Mr. OWEN. No, it is being leveled off. It has not at this stage in the game.

Chairman STARK. But I mean, if we are doing things right, it should go up, shouldn't it?

Mr. OWEN. Well, it depends on whether you are treating patients on an outpatient or inpatient basis, and the outpatient side is really zooming from that standpoint.

As I said before, I think that the prospective payment system was a step in the right direction. I think total prospective payments is also a step—if there is some assurance that these committed funds could be paid for, and that is where we have the problem.

Chairman STARK. Let's talk just for a minute while we have the opportunity to have you here about reporting, and mandatory reporting.

Mr. OWEN. All right.

Chairman STARK. Are you familiar with the California system?

Mr. OWEN. I know about it. I do not know if I could answer all your questions.

Chairman STARK. And there is a system called what, SHUR?

Mr. OWEN. Yes. I am familiar with that. Right. And I am familiar with the New Jersey system.

Chairman STARK. What was wrong with SHUR?

Mr. OWEN. SHUR was a cost-reporting accounting system that primarily tried to force hospitals to do uniform accounting and uniform bookkeeping, and that creates a problem.

Chairman STARK. To be on SHUR, it necessitated the hospitals to have uniform accounting?

Mr. OWEN. Well, if I remember right, SHUR, when it was coming in, I think it was a uniform accounting system.

Chairman STARK. Hospitals argued that, but it is not——

Mr. OWEN. Yes.

Chairman STARK. You are aware, that in California, hospitals can keep their books any which way they want?

Mr. OWEN. Yes, but they have to have uniform reporting.

Chairman STARK. But they have uniform reporting.

Mr. OWEN. That is right. And that is different.

Chairman STARK. This is quite different.

Mr. OWEN. That is different, yes.

Chairman STARK. And you are also aware, that if every State in the country had a different uniform reporting system, that all of

them, as long as the same general information is there, could be simply translated into a Federal uniform system of reports? You are aware of that?

Mr. OWEN. I guess that is what your—I am not aware of it, but you can tell me that that would happen.

Chairman STARK. Now wouldn't the American Hospital Association—we could have answered Mr. Pickle's question, couldn't we?

Mr. OWEN. I did.

Chairman STARK. If we had this kind of reporting——

Mr. OWEN. I can answer it.

Chairman STARK. I can answer this for you in California.

Mr. OWEN. I can answer it in Texas, too.

Chairman STARK. Yes, but actually, you cannot, because you would have to make some value judgments about the age of the existing buildings, and how soon they would need to replace their capital.

So, we could report about what might have happened last year, given a certain level of payments. But reports will not take the judgment factor away of what they ought to do, the normative decisions in the future.

But we would be a whole hell of a lot less speculative as to what would happen in rural areas, and what would happen to inner city areas, and——

Mr. OWEN. But see, I am not sure——

Chairman STARK. Would the American Hospital Association like to join our crusade to get a complete uniform system of reporting taking all income, and all expenses of all hospitals in the United States?

Mr. OWEN. And to do what with it?

Chairman STARK. And to have those reports made available for——

Mr. OWEN. Well, let me ask a question. Since you are only concerned with and your only responsibility is Medicare, why do you need the rest of that information?

Chairman STARK. Because it seems to me that Medicare is probably paying, in some cases—far more than half the cost of the hospitals. I would presume a hospital does not make any judgment in the quality it provides its patients, as to whether they are Medicare or non-Medicare, and because hospitals are asking us to reimburse them for charitable contributions which really are not Medicare's responsibility, and graduate teaching which inures to the benefit of all Americans, that we ought to have—I cannot look at your income and just take the income you get part-time from mowing lawns and babysitting.

I have to look at your lobbying income to decide how much tax you owe. So, to look at a hospital and say it is going broke, when it has 60 percent Medicare and 40 percent something else is not a factor, because they may be giving all their other care away, or they may be charging eight times more to the non-Medicare beneficiaries.

You cannot make a judgment on a particular hospital, or a group of hospitals unless you know all the facts. What if all these rural hospitals everybody is grumbling about do not have any Medicare

patients in them? I mean, maybe they do not have a problem, but I still think——

Mr. OWEN. But that would not have any effect on you, then.

Chairman STARK. But we do not know that, you see, and the way to know that is to have the income side of the equation. Do you have any objection to our having the income side of the equation?

Mr. OWEN. I personally do not have any objection to you having the income side of the equation, but my question again would be what other industry does the Government deal with in which they want that kind of information?

Chairman STARK. Oh, a lot. Defense. We used to renegotiate their profits as we are going to do for the hospitals this year on rebasing. That is an old Government policy. We have been doing it for centuries, ever since they sold beef, you know, cheap beef in the Civil War. It is one of those things. There is nothing new in this.

Mr. OWEN. Could I see some of those uniform reports, and if I saw some of those maybe I would have——

Chairman STARK. From California?

Mr. OWEN. No, no. I mean, some of those from defense industries, and some of the other ones that you say are uniform, so I would have an idea of what we are up against.

Chairman STARK. Oh, yes. Just look at any of the procurement lists. There are bookshelves of regulations for procurement. I would just say look at the California report, which I have heard generally regarded as the most useful and most efficient.

Every hospital does it, it does not cost them anything, they love it, and I think the rest of the country is going to love it. With the AHA's cooperation, think how much shorter all this testimony would be if we had the figures.

Mr. OWEN. That would be helpful. I agree.

Chairman STARK. We would cut out all those horse feathers that Mr. Pickle is talking about and get right down to numbers. Thank you.

Mr. OWEN. Thank you, Mr. Chairman.

Chairman STARK. As usual your testimony was of great help to the committee.

The committee is adjourned.

[Whereupon, at 3:17 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

Statement of Merlin K. DuVal, M.D., President,
American Healthcare Institute

Mr. Chairman, I am Merlin K. DuVal, M.D., President of the American Healthcare Institute. The American Healthcare Institute represents a national network of 32 voluntary, not-for-profit health systems linking 500 hospitals and 800 affiliated organizations known as American Healthcare Systems. It is the largest network of not-for-profit hospitals in the world, working to provide the American people with high quality care at an affordable price.

We appreciate this opportunity to share our views on Medicare capital payment policy. Medicare beneficiaries, and indeed all Americans, rely on our healthcare system to meet their need for high quality, accessible, and affordable care. Capital investments, and the financing of those investments, are vitally important factors in shaping the healthcare system to meet those needs, both now and in the future.

As you know, the hospital industry enthusiastically joined with the Congress and the Administration to change the incentives in hospital payments through enactment of the prospective payment system for operating costs in 1983. At that time, the decision was made to keep capital payments on a cost basis until October 1986, with the understanding that some changes would be considered. The Department of Health and Human Services was directed to develop a report and recommendations for paying for capital.

Although the department was unable to complete its report on a timely basis, the Administration recommended including capital within the prospective payment rates based on an unreasonably short (four year) transition period. Both the industry and the Congress quickly rejected that approach.

During 1986 the hospital industry worked hard to develop an alternative proposal for your consideration that went a long way toward addressing many of the inequities that must necessarily result from any policy change. A major weakness of the Administration's proposal was that it failed to accommodate to the need for "grandfathering," or continuing recognition and fair payment for capital costs incurred under Congressionally mandated health planning and reimbursement rules. Unlike operating costs, these institution-specific capital costs -- including interest and amortization of expenditures incurred previously -- are fixed costs that must be covered, for the same reason that most of us must meet mortgage payments. They are costs incurred in good faith by hospitals that followed applicable rules at the time of decision. While it is reasonable to ask hospitals to adjust their future purchases consistent with a fair policy on payment, it would be inequitable to punish some institutions and reward others for past behavior by changing the rules after the fact.

The Congress chose not to accept the hospital industry's reform proposal which was based on the grandfathering concept. Instead, Congress extended until October 1, 1987 the existing cost-related payments for capital. In addition, the Congress achieved three year budget savings of more than one billion dollars by reducing payments for those capital costs by 3.5 percent in FY 1987, 7 percent in FY 1988, and 10 percent in FY 1989. Thus, today we are paid 96.5 percent of costs, and by 1989 would be paid just 90 percent of capital costs under that phased reduction schedule. Our position today is that it would be preferable to proceed with that schedule rather than make a change now to incorporate capital into the prospective payment system.

The new competitive environment brought about by DRG payments, and by the increasingly cost-conscious actions of private purchasers of care, no longer provides financial resources for costs resulting from wasteful uses of capital. The new incentives provide appropriate marketplace pressure to assure that any capital investments made are necessary and appropriate,

and the hospital industry is responding to those new incentives. The volume of tax-exempt health care financings peaked at a high of $32.2 billion in 1985, and dropped to less than $6 billion in the first 10 months of 1986, according to ProPAC's recent report. More important, the percentage of those financings attributable to refinancings has grown over the past few years -- from 27.8 percent of total tax exempt financings in 1984, and 37.7 percent in 1985, to 45.8 percent in 1986. That means a smaller portion of the financing is going into construction or renovation.

Let me again emphasize our view that, for purposes of designing payment policies capital costs differ from operating costs in two important ways.

- First, capital costs are not only institution-specific but are unevenly distributed among hospitals and over time. Major capital expenditures for facility renovation or replacement occur infrequently, and are set in motion three to four years before they first appear on a hospital's Medicare cost-report. The timing of major capital expenditures varies among hospitals and the level of capital costs is a function of price levels and interest costs at the time of acquisition.

- Second, capital costs are fixed costs of assets generally purchased over lengthy periods of time. Hospitals must meet the principal and interest obligations on debt used to finance the purchase of these assets in much the same way that the rest of us have to meet mortgage payments on our houses. Hospitals must be prepared to replace assets at varying points in the future depending on where they are in the life cycle of their current assets.

As a result of these distinctions and variations in capital costs, even among efficient institutions, payments for capital costs on the basis of average prices -- which is the core of the prospective payment system for operating costs -- can have very serious effects on individual institutions at different points in their capital life-cycle. The policy presumption underlying Medicare's approach to prospective rates is that it produce a fair price based on that average, and that hospitals have both the incentive and the capacity to manage and change behavior to meet or better that price. However, resorting to the use of an average pricing strategy for capital expenses introduces a series of inequities that inappropriately penalizes some institutions and rewards others. Paying average costs for an expense that varies so greatly among institutions based on management decisions made much earlier is inequitable and risks grievous harm.

First, as noted before, capital costs are different from operating costs, and any policy change must be developed very carefully so as not to simply force these institutionally unique costs into an averaging system. Second, the Congress is already meeting its savings objectives through the phased reduction of 3.5, 7, and 10 percent over the next three years.

Mr. Chairman, because the new incentives in PPS are working, we oppose the adoption of any of the new methods for capital payments that have been proposed at this time. Any new system similar to the Administration's planned regulatory initiative would inevitably introduce new inequities without public policy benefits of equivalent value. In addition, the Administration's current proposal would simply redistribute Medicare capital payments in a manner that would place many hospitals in an untenable financial position, especially hospitals that have a high proportion of their capital costs for movable equipment.

We recognize our obligation to continue evaluating different proposals for improving the capital payment methodologies. As we examine potential revised policies, we would ask you to keep three key principles in mind:

1. Assure that any new rules fully recognize prior capital obligations made in good faith under the then existing rules to assure that past and current debt obligations can be met;

2. Allow adequate time in transition from present policies to minimize disruptions and assure continuing availability of a full range of services to Medicare beneficiaries;

3. Retain the current definition of "capital."

Thank you very much for this opportunity to submit our views. The American Healthcare Institute would be pleased to work with the subcommittee and staff as you address these issues in the future.

STATEMENT OF THE AMERICAN HEALTH PLANNING ASSOCIATION
TO THE
SUBCOMMITTEE ON HEALTH
HOUSE WAYS AND MEANS COMMITTEE
CONCERNING
MEDICARE CAPITAL PAYMENTS

The American Health Planning Association appreciates the opportunity to provide you with a statement of our recommendations concerning reimbursement of capital expenditures under the Medicare program. We believe the health planning community offers a unique perspective on the issue -- 20 years of experience attempting to restrain capital expenditures which have been reimbursed on a cost basis.

Having examined that collective experience of the States, studied the payment options for capital in detail, and listened to the testimony presented at the hearings of May 4, 1987, we make the following recommendations:

1. The Congress of the United States should enact prospective payment for Medicare capital as soon as possible. In general, we support the approach recommended by the Prospective Payment Assessment Commission (ProPAC), because:

- o Cost-based reimbursement provides inappropriate incentives to hospitals, which respond to those incentives by expanding capital projects that exceed the needs of the population served.

- o The hospital industry is seeking both continuation of cost-based reimbursement and a regulatory free environment within which incentives to expand for competitive market advantage will prevail.

- o The relatively recent experience of a tremendous expansion in services and facilities in the deregulated states of Arizona and Utah lead us to conclude that the management incentives inherent in the PPS for operating costs have not been strong enough to offset the inappropriate incentives in cost based payment for capital.

2. Regardless of the payment mechanism decided upon by Congress, we urge the immediate funding of an adequate data base to evaluate capital behavior and to guide further policy adjustments, because:

- o Despite the fact that a Medicare capital payment policy can affect the size and shape of the health care system for decades, the policy debate has been devoid of meaningful data, while full of dire predictions.

- o Studies of changes in capital spending behavior should have begun on enactment of PPS to examine how changes in operating cost incentives influenced capital and new technology.

- o Data are needed to evaluate the effects prospective payment for capital have on the health care system. A data system should be created to measure performance expectations. Examples of questions for study include -- Does the new policy encourage longer use of physical plant and equipment? Are hospitals showing increased sensitivity to market

demand and interest rates? Does the policy encourage the phase-out on unneeded and excess facilities? Are needed services being maintained for Medicare patients?

o Data are needed to evaluate separately the effects of capital reimbursement from the general effects of prospective payment.

3. We support the enactment of an equitable and reasonable outlier policy to provide adjustments for hospitals that might be adversely affected by prospective payment of capital, because:

o We believe that some much-needed hospitals in this country are undercapitalized and that an adjustment process is needed to ensure quality services to Federal beneficiaries.

The above recommendations represent a significant policy shift for our Association. AHPA previously advocated the continuation of cost-based reimbursement because of concerns that a prospective payment system for capital, for all its positive management incentives, was not designed to ensure that limited capital dollars would go to the areas of most need. Today we are more concerned that continued cost-based reimbursement without any form of restraint will result in greater maldistribution and excess.

We believed, and continue to believe, that a planning process is necessary to assist Federal payment policies by defining and identifying unmet needs and systemic excesses. We remain committed to the need for policies which balance cost, access, and quality. Today, hospital costs continue to escalate, while it becomes more difficult to assure access to care. We have come to the conclusion that cost-based reimbursement for capital, without restraint, will exacerbate that imbalance and therefore, urge the Congress to move towards prospective payment for capital as soon as possible.

STATEMENT OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES

The Association of American Medical Colleges (AAMC) which represents all of the nation's medical schools, 85 academic societies, and over 350 major teaching hospitals participating in the Medicare program, is vitally interested in proposals to change Medicare payment for hospital capital. As this subcommittee knows, the AAMC supported the concept of replacing cost reimbursement for hospital operating costs with a prospective pricing system. Since the enactment of that system, the AAMC has repeatedly appeared before this subcommittee to recommend refinements in the prospective pricing system which would more fully recognize legitimate differences in the costs of different hospitals. Some of those refinements have been made; others are still being debated. In this situation, where payments for basic operating costs do not fully reflect real differences in hospital costs, the AAMC recommends that any new payment system for hospital capital be approached with care and study. A new capital payment system must not be allowed to compound the weaknesses and inequities of the prospective pricing system for operating costs.

This AAMC statement on Medicare payments for hospital capital is organized into two sections. First, this statement reviews the state of the debate over Medicare payments for hospital capital and makes several observations about the current debate. Second, this statement provides the most up-to-date available data on the capital costs of teaching hospitals and concludes capital costs per unit of workload performed are higher in teaching than non-teaching hospitals.

THE CAPITAL DEBATE

While capital costs in hospitals are a small percentage of total hospital expenditures, they are a crucial consideration in an industry in which technological change is rapid and in which facilities to provide up-to-date diagnostic and treatment services are essential. As a result, few payment debates have generated as much controversy within the industry as Medicare payments for capital. Hospitals with recently completed or ongoing construction projects want to be "grandfathered" for decisions made in good faith under prior rules. Hospitals with old physical plants want to be paid enough so that they can attract the capital necessary to market bonds and other financial instruments. Lastly all hospitals, regardless of age, want to receive enough capital to modernize and provide up-to-date patient services in a competitive era.

In this contentious situation, a number of observations stand out:

1. The "lumpy" nature of capital expenditures traditionally means that different hospitals will view a single capital policy differently, and that a single, simple payment policy does not meet the varying needs of hospitals.

2. The long-term nature of prior capital spending means that hospitals must live in the future with the consequences of past decisions or face financial instability. Capital costs presently on the books are not subject to the same cost-cutting techniques that can be used with manhours per patient day.

3. If Medicare changes from cost reimbursement to prospective capital payments, the industry must transition from an era of capital recovery to an era of capital formation. The transition period requires more resources for capital because it includes both paying off old debt and accumulating the downpayment for new debt.

4. Given the fact that current law requires Medicare to pay less than its proportionate share of present hospital capital, present Medicare spending will not repay hospitals for the current stock of capital. New capital payment proposals which attempt to reduce payments further exacerbate the debate about capital within the hospital community.

5. Finally, while present occupancy rates suggest the aggregate existing supply of hospital beds meet more than present needs, there is no social process in place for deciding which hospitals are needed by their communities. In a competitive era, institutional survival may be based on economic strengths, not necessarily on community service. A single capital payment policy strengthens the role of economics in determining which hospitals shall survive. Unfortunately, the winnowing hand of economic survival is often blind to the service needs of the poor and the disadvantaged.

The implications of these observations are clear: there is no simple prospective payment policy for prospective capital payments which will simultaneously:

- o meet the capital needs of hospitals in different circumstances,
- o meet the needs of hospitals to modernize and the needs of government to economize, and
- o maintain the financial strength of needed hospitals while distributing funds using a formula which does not recognize the social contributions of hospitals.

These are not comforting conclusions; however, the AAMC believes they are accurate.

CAPITAL COSTS IN MAJOR TEACHING HOSPITALS

When Congress adopted the Medicare prospective payment system, capital costs of hospitals were excluded from the prospective payment and continued on a cost reimbursement basis. The AAMC recognizes this exclusion does not reflect a Congressional commitment to continuing cost reimbursement for capital. To date, however, Congress and the industry have been unable to identify a proposal which equitably meets the needs of hospitals at different points in the investment cycle. In part, the absence of a reasonable proposal reflects the presently inadequate, conflicting, and occassionally surprising information on capital costs of hospitals.

One of the first surprises in the government's initial analysis of 1981 hospital capital costs was the finding, by the Office of the Assistant Secretary for Planning and Evaluation (ASPE), that the capital costs in hospitals belonging to the Council of Teaching Hospitals (COTH) averaged 5.01% of total expenses while capital costs in non-COTH hospitals averaged 7.17%. Of equal significance was the ASPE finding that COTH members were consistently more heavily concentrated in the low capital cost categories, Table 1. Other ASPE analyses tended to corroborate the unexpected COTH/non-COTH differences in capital costs. As shown in Table 2, lower capital costs were also found in hospitals with CT scanners, pediatric/neonatal intensive care units, open heart surgery services, and Medicare case mix indices greater than 1.1.

Table 3 shows depreciation and interest expenses as a percentage of total hospital expenses for COTH and non-COTH hospitals in 1985. It should be noted that the interest expense percentage includes both interest paid on capital indebtedness and interest paid on working capital because the American Hospital Association's Annual Survey of Hospitals does not differentiate them. COTH members, as a group, report a lower percentage of expenses for depreciation, interest and depreciation plus interest. This is consistent with the ASPE findings.

In Table 4, depreciation and interest expenses for COTH and non-COTH hospitals are computed on a unit of workload basis using adjusted census days, adjusted patient days and adjusted admissions. Because depreciation and interest are reported on a hospital-wide basis, it is important to have a workload measure that represents both inpatient and outpatient services. The "adjusted" data provide a comprehensive measure of hospital workload by increasing actual inpatient workload by a hospital specific factor designed to convert outpatient services into inpatient workload equivalents. For depreciation expenses, COTH hospitals report significantly higher expenses per workload unit. For interest expense, COTH members have a higher cost per admission but a lower cost per census day or per patient day. When depreciation and interest are combined, COTH hospitals have higher costs. This finding of higher capital costs per unit of workload but lower costs as a percentage of expenses is also supported when depreciation and interest expenses per adjusted admission for COTH and non-COTH hospitals are compared by census region, Table 5. Thus, major teaching hospitals have significantly higher capital costs per unit of workload than other hospitals.

The data analysis clarifies somewhat the capital costs of teaching hospitals. Major teaching hospitals do have greater absolute capital expenditures per unit of workload than other hospitals. At the same time, COTH members have relatively smaller capital costs when capital costs are compared to total hospital expenses. This finding has significant implications in evaluating capital payment proposals from the perspective of major teaching hospitals. Using historical data as an indicator of future relationships, the acceptability

of a uniform capital "add-on" to the DRG payment system depends on major teaching hospitals receiving a percentage "add-on" computed using the total of basic DRG payments plus the resident-to-bed adjustment as the base against which the percentage is applied.

In summary:

- o historical data which compare capital costs to total expenses have b en misinterpreted by some to imply that major teaching hospitals have lower absolute capital costs than other hospitals; and

- o capital costs per unit of workload performed are higher in major teaching than in other hospitals.

CONCLUSION

If the Medicare system for paying hospitals for capital costs is to be changed, the AAMC believes great care should be taken before the change is made. The DRG system for paying operating costs was preceded by several years of research and a number of demonstration projects. No similar effort has been made for capital payments.

The Administration's proposed budget for fiscal year 1988 advocates implementing a new policy for Medicare payments by regulation rather than legislation. The AAMC is opposed to changing Medicare capital payments by regulation. A new capital policy necessarily involves balancing conflicting viewpoints and impacts. While the regulatory process includes an opportunity for public comment, the comments are often ignored and decisions on critical choices are made in closed meetings. The legislative process is preferred because it is more open and public. To ensure that the legislative process has an opportunity to consider a new capital payment policy:

> THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES RECOMMENDS THAT THIS SUBCOMMITTEE ADOPT LEGISLATION PROHIBITING THE SECRETARY OF HHS FROM MAKING CHANGES IN THE PRESENT CAPITAL PASSTHROUGH UNTIL CONGRESS ENACTS LEGISLATION DIRECTING THE SECRETARY TO IMPLEMENT A SPECIFIC CAPITAL PAYMENT METHODOLOGY.

Developing a new approach to paying for capital involves trying to solve two difficult problems simultaneously. First, hospitals must make a transition from a period of retrospective recovery of capital costs to a new era of a priori capital development formation. This takes time. Secondly, hospitals are at differing points in a very "lumpy" capital cycle which is characterized by high costs when facilities are new and by low costs when facilities are old. This requires attention to hospitals at both ends of the cycle. To develop a new capital policy which preserves the financial viability of hospitals while treating them equitably will be most difficult.

Table 1

Percentage Distribution of Capital Costs as a Percentage of Total Expenses by Membership in the Council of Teaching Hospitals, FY 1981

Percentage of Capital Costs	Percentage of Hospitals	
	COTH	Non-COTH
Less than 4%	37%	25%
4% to 6.57%	39	34
6.58% to 9.99%	17	23
10.0% to 14.99%	6	13
15% to 19.99%	1	4
20% or more	1	2
TOTAL	101%	101%

Source: Office of the Assistant Secretary for Planning and Evaluation, DHHS.

Table 2

Capital Costs as a Percentage of Total Costs by Selected Hospital Characteristics, FY 1981

Hospital Characteristic	Number of Hospitals	Mean Percentage of Expenses for Capital Costs
CT Scanner		
Yes	1108	6.47%
No	3867	6.75
Pediatric/Neonatal ICU		
Yes	1215	6.09
No	3760	7.09
Open Heart Surgery		
Yes	463	6.09
No	4512	6.85
Medicare Case Mix Index		
Less than .9	862	5.64
0.9 - 1.0	1517	6.72
1.0 - 1.1	1631	7.16
More than 1.1	814	6.07

Source: Office of the Assistant Secretary for Planning and Evaluation, DHHS.

Table 3

Depreciation and Interest as a Percentage of Total Expenses for COTH and Non-COTH Hospitals, 1985

Expense Type	Percent of Total Expenses	
	COTH Members	Non-COTH
Depreciation	4.8%	5.1%
Interest	2.2	3.1
Depreciation and Interest	7.0	8.2

Source: AHA Annual Survey, 1985 data.

Table 4

Depreciation and Interest Expenses per Adjusted Census Day, Adjusted Patient Day, and Adjusted Admission in COTH and Non-COTH Hospitals, 1985

Workload Unit	Expenses per Workload Unit					
	Depreciation		Interest		Depreciation & Inter	
	COTH	Non-COTH	COTH	Non-COTH	COTH	Non-COTH
Per Adjusted Census Day*	$12,614	$9,742	$5,864	$6,157	$18,478	$15,899
Per Adjusted Patient Day	28.99	21.58	13.61	13.77	42.60	35.35
Per Adjusted Admission	228.72	138.79	107.12	87.63	335.84	226.42

Source: AHA Annual Survey, 1985 data.

* A census day is equal to one bed occupied for 365 days. It is computed by dividing tptal patient days by 365.

/ Table 5

1985 Depreciation and Interest Expenses per Adjusted Admission in Short-Stay, Non-Federal Hospitals by Membership in COTH and Census Region

Region	1985 Depreciation and Interest Expenses Per Adjusted Admission	
	COTH	Non-COTH
New England	$314.93	$221.21
Middle Atlantic	392.92	241.97
South Atlantic	243.23	231.87
East North Central	348.30	234.53
East South Central	323.82	187.37
West North Central	357.83	198.78
West South Central	315.39	204.63
Mountain	319.0[illegible]	245.44
Pacific	297.7[illegible]	289.36
National	[illegible]	226.42

Source: AHA Hospital Survey, [illegible] data.

STATEMENT OF

THE NATIONAL COUNCIL OF HEALTH FACILITIES FINANCE AUTHORITIES

I. Introduction

The National Council of Health Facilities Finance Authorities is the national association of agencies that issue tax-exempt bonds on behalf of nonprofit health care facilities. These bonds are used to construct new facilities, to replace or renovate existing facilities, and to provide funds for major equipment purchases.

The authorities were created by state legislation to further the public purpose of providing quality health care facilities. Their boards of directors are appointed by the Governor or state legislature. The members of the Council, over 20 state authorities and one major metropolitan area authority, issue a substantial amount of the tax-exempt bonds for nonprofit health care institutions.

The Council is interested in proposals to incorporate Medicare capital expenditure reimbursement in the Prospective Payment System (PPS) because of concerns that this could result in defaults of outstanding bonds and the inabilty of institutions to issue bonds in the future. Our analysis of the Administration's June 1986 proposal against the portfolios of two large states, New York and New Jersey, showed that it would lead to substantial numbers of defaults on outstanding mortgages made by members of the Council and would deny many hospitals capital need in the future to maintain and improve the quality of medical care.

We also evaluated several proposals generated by Congressional staff in 1986 against these portfolios and found that even with very complicated provisions to minimize the hardship on hospitals, there would be substantial adverse effects on hospitals that had gone to the bond market for substantial financing in the last few years, and those intending to go the market in the near future.

II. Position of Council

While we have not had sufficient time to analyze the impact of the Administration's May 1987 proposal, we are concerned that the perceived benefits of having all Medicare payments under PPS may be outweighed by the adverse impacts of the proposal on the health care system no matter what specific formula is employed.

This is because, as Congress recognized when it enacted PPS in 1983, capital costs are different from operating expenses in important ways. The primary sources of the difference are:

1. The cost cycle for hospital capital expenditures is long and varies considerably over the cycle. Over 75 percent of all major hospital construction projects are financed with long-term debt. There are vastly different impacts on hospitals

depending on their place in the cycle and the amount of investment most recently made. This is very different than the situation regarding operating costs.

2. The hospitals are not able to adjust their behavior to reduce their capital costs as fast as the phased-in incorporation of capital payments into PPS would reduce their reimbursement. This also is very different than the situation regarding operating costs.

It is the Council's position that Congress should retain the current law "restricted passthrough" rules for the reimbursement of hospital capital costs under Medicare for the following reasons:

A. The realities of hospital capital costs are inconsistent with the theory and practice of PPS

Hospital capital costs and capital costs per discharge vary enormously (from 2 to 40 percent of operating costs) between hospitals. These variances are based on factors including:

1. The position of the hospital in its capital cycle, which is characterized by infrequent but very large expenditures;

2. Prior levels of investment and the age of the investment;

3. Changes in occupancy rates;

4. Local construction costs, the prevailing interest rates and other cost factors occurring when the project was financed and constructed; and

5. Current community needs driving future hospital capital needs.

Analyses of capital costs of hospitals has shown that these costs do not correlate well according to the type of facility, its ownership, its size, its location, whether it is a teaching hospital, the intensity of care, or the other conventional methods of categorizing hospitals.

Capital costs cannot be changed as operating costs can. They can only be changed by either refunding the debt, which may be impossible because of high interest rates or legal prohibitions, or by selling assets which is generally impossible without closing the facility.

B. No further budget savings will result from incorporating capital payments in PPS

All budgetary savings contemplated from incorporation of capital reimbursement into PPS, $1.1 billion by FY 1989, will occur under current law and cannot be increased by regulations incorporating capital into PPS. In addition, further savings from hospital capital payment reductions would be unwarranted and dangerous.

C. Incorporating capital payments in PPS will unnecessarily harm the health care system

The incorporation of capital reimbursement into PPS is unnecessary to meet Congressional budgetary objectives. Capital spending restraint will continue to occur without the incorporation of capital reimbursement payments into PPS because of the reductions in PPS operating payments, which are more than ten times the level of capital payments on average. In addition, the several new restrictions on tax-exempt financing imposed by Congress in the Tax Reform Act of 1986 also will restrain new capital investments and further insure that they are only made where justified by community need.

Incorporation of capital reimbursement into PPS will harm the health care system when it fails to provide adequate reimbursement for high capital cost hospitals. This will prevent necessary upgrading of facilities to preserve quality of care and perhaps endanger the existence of high capital cost hospitals by increasing the risk of default on their debt obligations. It also will cause a diminuation in the confidence of financial markets in hospital debt and equity issues generally, which will deny access to or increase the cost of capital to hospitals in the future, including Medicare's share of that cost.

III. Conclusion

The Council will carefully evaluate the impact of the Administration's new proposal to incorporate capital into PPS and will make this evaluation available to Congress and the Administration. At this point, however, we believe that the theoretical advantages of incorporating Medicare reimbursement for capital expenses in PPS are far outweighed the practical damage to important elements in the health care system.

In a prospective payment system for capital where some hospitals will "win" and some will "lose," we are concerned that the positive impact on the finances of the winners will be far outweighed by the negative impact on the health care system from the harm done to the losers, the communities they serve, and to the financing system for all hospitals.

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